



COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

ANNUAL REPORTS

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL
OFFICER

YEAR 1960

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HEALTH DEPARTMENT, COUNTY HALL, WAKEFIELD

TELEPHONE 3781

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(as at 31.12.60)

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VICE-CHAIRMAN

County Alderman N. Carter

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Hyman, W. M. <i>(Chairman of the County Council)</i>	Thackray, C., B.A.
	Whittock, M.

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Illingsworth, S.	

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(as at 31.12.60)

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Hudson, Major J. H., C.B.E., M.C., D.L. (<i>Vice-Chairman of the County Council</i>)	Smith, Mrs. J. (<i>Chairman of the Finance Committee</i>)
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Morris, Sir Charles, M.A.	Whittaker, Dr. J. M., F.R.S.

STANDING SUB-COMMITTEES OF THE WEST RIDING HEALTH COMMITTEE

Ambulance Sub-Committee.—All matters relating to the County Ambulance Service. (Section 27, National Health Service Act, 1946.)

Public Health Sub-Committee.—Matters relating to the Pharmacy and Poisons Act, 1933; Housing (Rural Workers) Acts, 1926 and 1942; Housing Acts; Rural Water Supplies and Sewerage Acts, 1944-55; Nurses' Act, 1957; Vaccination and Immunisation (Section 26), Venereal Diseases, Public Health Propaganda (Section 28), under the National Health Service Act, 1946; Food and Drugs Act, 1955; Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53; Shops Act, 1950; and all other powers and duties of the Health Authority not delegated to another Standing Sub-Committee.

Mental Health Sub-Committee.—All matters relating to the duties of the Local Health Authority under the Mental Health Act, 1959, and the care and after-care of persons suffering from mental disorder. (Section 28, National Health Service Act, 1946.)

Welfare Sub-Committee.—Arrangements for the prevention of illness, the care of persons suffering from illness other than mental illness, or the after-care of such persons. (Section 28, National Health Service Act, 1946, and the Public Health (Tuberculosis) Regulations, 1952.)

Arrangements for promoting the welfare of persons who are blind, deaf or dumb and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity, or such other disabilities as may be prescribed by the Minister of Health, and arrangements with Voluntary Organisations therefor. (Sections 29 and 30, National Assistance Act, 1948.)

Assistance grants to Voluntary Organisations providing meals or recreational facilities for old people. (Section 31, National Assistance Act, 1948.)

Arrangements for the protection of property of persons admitted to hospitals, etc. (Section 48, National Assistance Act, 1948.)

The recovery of charges and expenses where permissible in respect of all services provided by the Health Committee.

The West Riding Distress Fund.

Welfare Accommodation Sub-Committee.—The provision and management of residential accommodation for persons who, by reason of age, infirmity or any other circumstances, are in need of care and attention which is not otherwise available to them. (Sections 21-24, National Assistance Act, 1948.)

Arrangements with Voluntary Organisations and other Local Authorities for the provision of accommodation in property maintained by them. (Section 26, National Assistance Act, 1948.)

The registration of disabled persons' or aged persons' homes. (Sections 37-39, National Assistance Act, 1948.)

Registration of charities for disabled persons. (Section 41, National Assistance Act, 1948.)

Care of Mothers and Young Children and Nursing Services Sub-Committee.—The duties of the County Council in respect of Nursing Homes (Sections 187-195) and Notification of Births (Section 203), under the Public Health Act, 1936; the care of mothers and young children (Section 22), domiciliary midwifery (Section 23), health visiting (Section 24), home nursing (Section 25) and domestic help (Section 29) services under the National Health Service Act, 1946; the Nursery and Child Minders Regulation Act, 1948; and the Midwives Act, 1951.

JOINT STANDING SUB-COMMITTEE OF THE WEST RIDING HEALTH AND EDUCATION COMMITTEES

Divisional, School Health and Dental Services Sub-Committee.—All matters appertaining to the Divisional Health Administration (Section 111, Local Government Act, 1933); and the School Health and County Dental Services. (Education Act, 1944.)

STANDING SUB-COMMITTEE OF THE WEST RIDING EDUCATION COMMITTEE

Special Services Sub-Committee.—All matters appertaining to the ascertainment of handicapped pupils and the provision of special educational treatment. (Education Act, 1944.)

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INTRODUCTION

Annual reports can be difficult to read. One is faced with the choice of compiling a magazine type of document which, although readable, may not be very informative, or producing a document containing as many facts as possible and which is unlikely to be read. The latter has the merit of being a reference book which we all find valuable for the day-to-day running of the services. I have tried in writing the current report to attempt to combine the two by giving as much factual information as possible interspersed with explanatory reading matter and reports. It is, therefore, left to me in the introduction to draw attention to some of the more important items in the hope that subjects which interest the reader will be more deeply studied. Full details of the year's progress cannot, of course, be obtained without more detailed perusal of the report.

The amalgamation of Divisions 7 and 8, Divisions 27 and 28 and of Divisions 26 and 30 have now been effected, giving in each case a population of over 100,000. This reduces our original 31 divisions to 23. The pursuance of the County Council's policy in this direction has now brought us to within striking distance of the ultimate goal of 18 divisions. With the recent addition of Queensbury and Shelf U.D. to our general divisional pattern we have now a unified scheme of divisional administration throughout the County and one is tempted to question whether the time is not now ripe for a re-appraisal of the whole system. Now that the divisions are approaching the 100,000 population mark we are nearing the point when they can be largely self-contained for day-to-day administration, because of the greater resources which are available within the enlarged division. It would seem that we must carefully compare our present divisional scheme with what could be achieved by the appointment of divisional committees for these areas. A further development could be the adjustment of some divisional boundaries to bring together more completely the work of the education, welfare, health and children's departments by making all the divisional areas coterminous. Administratively this is an attractive proposal and might well lead to more easy access of the general public to our services. These are problems which I am sure must be fairly and squarely faced during the coming year, and particularly at a time when boundary reviews are being studied with great care throughout the country.

Last year I reported details of the scheme which would be operated under the new Mental Health Act. This year the reader can see how we have developed this scheme. A year ago I was not very optimistic about the speed with which we could achieve useful results, but in the event I have been proved wrong. Already the required staff have been appointed and the building up of liaison with the hospitals has proceeded rapidly. The swiftness with which our plans have been transferred from paper to practice has been extraordinary and surprising. When we have completed our present and approved building programme for training centres we shall need only three more centres to satisfy the demand as known at present. The revolutionary nature of the changes brought about by the Mental Health Act and the speed of its development has, of course, brought its teething troubles, but the staff have been very enthusiastic and I see no reason why all our difficulties should not be overcome very soon. Naturally a good deal still remains to be done in order to finally fashion the service. We have still to develop our hostels and our social clubs, and

much needs to be done by way of training the staff. To this end I am very glad to have been able to arrange jointly with the National Association for Mental Health for a Tutor to be appointed who will be of inestimable value, because we must rely on our own training resources for a long time until national organisations can produce fully trained workers. I would like to express my gratitude to the County Welfare Officer and his staff for the way in which they continued to help us out with the compulsory removal of mentally-ill patients until we were in a position to take over the full load of work ourselves. Their help has been invaluable.

The chiropody scheme was also described in detail in my last report and it is now possible to report on the first ten months of its implementation. A surprising change has come about and the volume of work carried out in such a short time has been almost embarrassing. The scheme which was necessarily tentative because of our lack of experience has been fully justified in the light of the report recently issued by the National Corporation for the Care of Old People and which deals with a three year study of the problem. Our own scheme follows almost identically the recommendations of this report. In the event some 95 voluntary bodies undertook to act as our agents and 14 of our divisions conducted a direct service and between them they treated 19,918 patients in the first ten months of operation and gave 69,439 treatments. This represents some 9 per cent. of the pensionable population who are eligible for this service. The actual need of old age pensioners is not firmly known although some assessments of 15 per cent. have been made. Some of our divisions have already reached this figure. We are not aware that any needy patient is waiting for treatment so that it will be interesting to see how much further this service will need to expand. Much, of course, depends on the availability of chiropodists.

Our discussions last year with the District Councils on the best ways of assisting them with the problem of families likely to be evicted for the non-payment of rent have progressed. It was decided that intermediate accommodation for such families was not a satisfactory solution, but some assistance to District Councils in their housing finances has been made available with the object of preventing children of evicted families having to come into the care of the County Council and to give an opportunity for rehabilitation. The scheme shows signs of obtaining satisfactory results in a fair proportion of cases.

We have now brought to completion the Committee's policy of appointing Divisional Nursing Officers to all our divisions except the smallest. The small divisions are served by Area Nursing Officers. Thus we have complete decentralisation of day-to-day administration through the Divisional Medical Officers and the Divisional Nursing Officers. This has the decided advantage of avoiding a tight central control.

The report on the School Health Service gives our provisional thoughts on the new scheme of medical inspections being tried out in two of our divisions. The intermediate inspection has now been abandoned in these areas and substituted by selective examinations after consultation with parents and teachers. This gives a closer link between the doctors, teachers and parents, and it is encouraging to learn that the Divisional Medical Officers concerned feel that, although adjustments to the scheme will be necessary, it is proving successful and has had the effect of bringing to our notice more defects which need treatment than was hitherto possible. More experience of the scheme is necessary before a final assessment is made. We have also concentrated on

the detection of deafness in its early stages by training our staff in simple methods of detection, for which I am grateful to the Manchester University Department for the Education of the Deaf. We have also provided more audiometers for routine testing of vulnerable groups of children. We have now added to this the setting up of two special clinics of our own for the assessment of difficult cases. Another point of interest is the introduction of teachers for the maladjusted into some of our child guidance clinics.

The Child Guidance Service gives cause for anxiety in view of the grave national shortage of psychiatrists and psychiatric social workers. The Regional Hospital Boards are tending to lose the services of Child Psychiatrists and are not able to obtain replacements, hence our clinics suffer considerably. There would appear to be no immediate prospect of improvement. It may well be, therefore, that we shall have to rely upon our own resources to a considerable extent. This may be possible by the use of selected Assistant Medical Officers and Health Visitors who have undergone some training. It is well known that a lot of the material dealt with at child guidance clinics does not need the service of highly skilled psychiatrists, and much of the work could be done by our own staff, thus filtering off the more difficult problems to be dealt with by the available psychiatrists. This idea is only in its formative stage at the moment, but in principle it has already received warm support from many of those officers likely to be closely involved with the problem. It is a matter which must be considered further during the coming year.

The medical aspects of the ambulance service have been studied carefully and several interesting developments have been introduced. We have studied the type of first aid equipment which should be carried in ambulances and have advised accordingly. We have also re-organised the methods of resuscitation and have decided to teach to our personnel the direct mouth-to-mouth method of artificial respiration. Apparatus for this purpose has been obtained and we may well have to consider not only resuscitation by artificial respiration but the use of external methods of cardiac massage in cases of heart failure. Both these techniques may be life saving. The new methods of resuscitation plus the increasing severity of road injuries under modern conditions have caused us to consider more advanced methods of first aid training for the ambulance personnel, and with this in mind arrangements have been made between ourselves and the Regional Hospital Board and the Leeds General Infirmary for short courses of instruction.

For those who are statistically minded a few facts taken at random from the report may be interesting. The birth rate is 16·9, the highest since 1949. The death rate is 11·5, the lowest recorded since 1948. The infant mortality rate is 22, again the lowest ever recorded in the West Riding. We are used to the assertion that cancer incidence is on the increase, but in 1960 in the West Riding there was no increase over the previous year; this, of course, may be a normal fluctuation in the general upward trend; but it nevertheless leads to the hope that the position is stabilising. The same applies to venereal disease, which for the past few years has been on the increase, but which at least in respect of syphilis and gonorrhœa would appear to be stabilising—at least we must hope so. I would recommend readers to the excellent report in these pages by Dr. Burgess which gives a much fuller story. Food poisonings are still on the increase and these facts make depressing reading. On the other hand we have had no case of diphtheria, and the number of children immunised before the age of one year (65·8 per cent. of births) is rapidly on the increase. This is most encouraging. We must try to reach 75 per cent.

as soon as possible and then we can feel reasonably satisfied. The number of poliomyelitis cases—6— is the lowest on record since 1947 but this must not lead us to complacency for the disease is by no means yet fully checked. Whooping cough has increased considerably, it being an epidemic year, but it is most interesting to read that of the 3,169 notifications at ages 0—14 years only 421 of them had been immunised, and if we couple this fact with the knowledge that only about 50 per cent. of our 0—4 years old population have been immunised it speaks well of the effectiveness of this type of inoculation. Tuberculosis deaths and notifications continue on their downward trend. The deaths from heart disease have increased, as one might expect with an ageing population and because of the continued increase of coronary heart disease. Although the total number of deaths from violence has not increased the figures show a very sombre picture when we look at the number of deaths on our roads. Violent deaths from motor vehicles continue to increase in number year by year.

Our capital building programme has mounted apace during the last twelve months. As already mentioned our training centre programme is nearing completion, and we are well ahead with the building of clinics. Of our 228 permanent clinics no less than 106 (including the present building programme), will have been purpose-built or extensively adapted since the War. With the completion of our present programme our major projects will be behind us and we shall need to concentrate shortly on the building of relatively small clinics in less populated areas. Our building programme may thus change in character in a few years' time and we shall be more involved with the construction of hostels, and possibly divisional administration offices.

The problem of immunisation and vaccination against infectious diseases becomes more complicated each year as research extends and gives us the use of a greater variety of antigens and the possibility of preventing more diseases. We are now attempting to protect against smallpox, diphtheria, whooping cough, tetanus, poliomyelitis and tuberculosis. This formidable list and the methods used can be confusing to both parents and doctors alike. Consequently we have attempted to rationalise the procedure in the light of more recent scientific advice and have adopted a plan which is set out in detail on page 51 and which has had considerable success and has reduced the inconvenience to all concerned. We have also tried to help the parents and the general practitioners by giving every individual a record of his immunisation state. The card also contains the date of the next appointment for immunisation where appropriate. This card is meant to be available to any doctor dealing with the patient and is especially valuable to hospitals when dealing with an injured patient who may need protection against tetanus.

I am very grateful to the general practitioners and to the Local Medical Committee for their continued interest in our activities and for the time some of them spend on our Standing Sub-Committee on Co-operation discussing mutual problems. In this way we have been able to overcome many difficulties which would otherwise have arisen. On page 45 we have published for the first time a list of the various matters discussed by this Committee, and it gives some indication of the wide field of common interest, and our experience shows how important it is that these matters should indeed be discussed jointly. I am grateful too to the Divisional Medical Officers for their increasing interest in our monthly deliberations. So much work has been done both at the conferences and at special sub-committees of the conferences that it has been necessary to index the items of discussion in order that easy reference may be obtained. I am completely convinced that this method of administration of

the services by keeping in close contact with general practitioners and Divisional Medical Officers is most rewarding.

A special report appears in these pages on the development of our health education programme. This has been possible by the appointment of a Deputy County Nursing Officer who takes a special interest in this work and is able now to use the newly appointed Divisional Nursing Officers to expand the scheme. Much has been accomplished already and further expansion will become apparent year by year.

The Cranbrook Report on the Maternity Services, which has been adopted by the Government, laid special emphasis on increasing the number of hospital confinements. This naturally has had an influence on the midwifery work of local health authorities, and in some areas attendance at formal ante natal clinics has fallen. On the other hand it is becoming apparent that local health authorities have an increasing duty in these circumstances of ensuring that health education in the form of mothercraft training be made available to those expectant mothers who are increasingly obtaining their ante natal care at hospitals. Fortunately we are in a position to offer these services because we have developed a considerable number of clinics conducted jointly by midwives and health visitors for the very purpose of health education, and it is interesting to note the large number of hospital cases which already attend. This change in emphasis in the content of our ante natal work is fully expressed and reported upon on page 89 of this report.

We have tried to alleviate the lot of the incontinent patient nursed at home and in so doing to increase the facilities available to home nurses in their difficult task. A start has been made in some divisions where arrangements have been made with either the local hospital or the nearest Welfare Home for the laundering of the linen from incontinent patients and which has been supplied through our after-care service. This will not be possible in most parts of the County and therefore an alternative is being made available by the supply of large specially prepared incontinent pads. It is hoped in this way to ease the burden of all concerned.

The stress of accumulating work on the part of clerical staffs has been apparent for a number of years as a result of increased activities in the divisional offices. It has, therefore, been necessary to make a complete re-appraisal of the number and gradings of office staff. The task has now been successfully completed and the result approved by the County Council and is in process of being implemented. The increased number of staff and the improved staffing structure will undoubtedly be welcomed throughout the service and should eventually relieve the pressure which has gradually accumulated.

The home help service continues to grow and the demand on it increases because of the greater number of aged people in the community. It has now been necessary to put up the establishment to the equivalent of 1,000 full-time helps. Practically all of this is given in terms of part-time work.

The dental service for children and expectant and nursing mothers continues to fight the ever increasing problem of dental decay. Much as we are proud of the service we have, it is not enough, and until more dentists are available and dental auxiliaries become trained the problem will continue. It is, therefore, increasingly necessary to do what we can to protect children from unnecessary dental caries. Here, as an education authority, we have a part to play and must

avoid being placed in the false position of being unable to deal with the sum total of dental decay on the one hand and condoning the sale of excess sweets in our schools, as more than enough is available outside. This is a problem which must be courageously faced.

It is often assumed by those not intimately connected with the subject that the mother of an illegitimate child resorts in most cases to adoption. We do not, of course, deal with all cases of illegitimacy but of the 828 cases with which we were involved some 509 mothers decided to keep their babies, that is 60 per cent. which does I think put the whole matter in a better perspective.

Modern research demands the facilities of highly trained personnel and the resources of special organisations, but in spite of this there are many ways in which health departments can be of assistance. Arrangements have been made for work during 1961 to be carried out in the first place in connection with the Department of Social Medicine at Oxford University in a survey of cancer cases, with the object of showing that genetic changes have some bearing on the problem of cancer formation, and in the second place in conjunction with the University of Sheffield on the behaviour of live poliomyelitis vaccines. It is hoped that the coming year will give some indication of the value of this work.

As for the future there are several developments in mind as follows:—

Complete local agreement has now been reached on the health centre project at Cleckheaton, and we are awaiting the Ministry's observations on the plans and site, and hope that we shall be able to start the work in 1961.

New methods of sterilising syringes are being experimented with. This has become necessary as a result of increased knowledge of the behaviour of virus infections and the work carried out by the Medical Research Council on the effectiveness of present methods. The coming year will show great changes in our methods of using this new knowledge.

It is hoped to introduce a service in conjunction with the Marie Curie Foundation for the complete nursing of severe cases of cancer in their own homes.

We shall introduce a re-organised scheme for the district training of our home nurses. Hitherto we have relied entirely on other authorities for this service, but soon we expect to be largely independent and to conduct our own scheme.

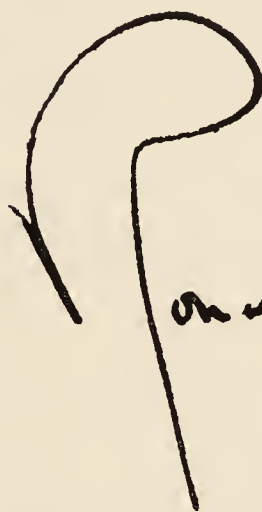
Although Britain has a fairly good record in the survival rates of our premature infants we are still not doing as well as some other countries. In the light of this and the advice given by the Ministry to hospitals and local authorities we anticipate developing new methods of approach to the problem.

Certain changes have occurred in the responsibilities of Counties for environmental hygiene, particularly in the work involved with the sale of milk. This may well lead to some re-organisation of the department.

We are studying the value of our medical examinations of persons applying to enter the superannuation scheme as we are not satisfied that the medical manpower is used to the best advantage and we may well be suggesting some amendment to our scheme.

These are some of the problems we hope to tackle in the coming year.

Dr. Leiper gave valued service as my Deputy until he left during the year to take up his new duties as County Medical Officer to the Cumberland County Council. I wish him well in his new appointment which, I am sure, he will fill with distinction. I would like to express my most grateful thanks to every member of the health department staff for their great assistance and cheerful help during what has been a difficult year. It has been difficult partly because of our increasing responsibilities, but also because of the extra strain caused by the large amount of work which has had to be done in connection with Boundary Commission enquiries. I would also add my thanks to the Committee members and the chief officers and staff of many other County Council Departments for their solid support during the year.

 W. Leiper
County Medical Officer.

County Health Department,
County Hall,
Wakefield.

July, 1961.

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1960

MEDICAL STAFF

County Medical Officer and Principal School Medical Officer	Ronald W. Elliott, M.D., M.Sc., D.P.H.
Deputy County Medical Officer	J. Lyons, M.B., CH.B., M.R.C.S., L.R.C.P., D.P.H.
Senior Medical Officers ...	J. M. Anderson, M.R.C.S., L.R.C.P. Annabella Marshall, M.B., CH.B.
Venereologist (part-time) ...	J. A. Burgess, M.D., CH.B., D.P.H.
Pædiatrician (part-time) ...	C. C. Harvey, B.Sc., M.D., B.S., F.R.C.S. M.R.C.P.
Obstetrician (Joint appointment with Hospital Services)	J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P.S., D.OBST.R.C.O.G.

Divisional Medical Officers—

Division No.

1 (Skipton) ...	M. Hunter, M.B.E., M.D., CH.B., D.P.H.
3 (Keighley) ...	V. P. McDonagh, M.B., CH.B., D.P.H.
4 (Shipley) ...	J. Battersby, M.B., CH.B., D.P.H.
5 (Horsforth) ...	A. Telford Burn, M.B., B.S., D.P.H.
7 (Harrogate) ...	N. V. Hepple, M.D., B.S., B.HY., D.P.H.
9 (Wetherby) ...	R. G. Smithson, M.D., CH.B., D.P.H.
10 (Goole) ...	S. K. Appleton, M.D., CH.B., D.P.H., D.T.M.
11 (Castleford) ...	J. M. Paterson, M.B., CH.B., D.P.H.
12 (Pontefract) ...	J. F. Fraser, M.B., B.S., D.P.H., D.OBST.R.C.O.G.
13 (Morley) ...	A. Withnell, B.Sc., M.D., CH.B., D.P.H.
15 (Batley) ...	J. F. Caithness, M.B., CH.B., D.P.H.
16 (Rothwell) ...	A. L. Taylor, M.D., CH.B., D.P.H., L.D.S.
17 (Spenborough) ...	W. M. Douglas, M.B., CH.B., D.P.H.
18 (Brighouse) ...	F. Appleton, M.B., CH.B., D.P.H.
19 (Todmorden) ...	N. E. Gordon, M.B., CH.B., D.P.H.
20 (Colne Valley) ...	E. Ward, M.R.C.S., L.R.C.P., D.P.H.
22 (Wortley) ...	J. Main Russell, M.B., CH.B., B.HY., D.P.H.
23 (Hemsworth) ...	J. S. Walters, M.C., M.B., CH.B., D.P.H.
25 (Barnsley) ...	R. Barnes, B.A., M.R.C.S., L.R.C.P., D.P.H.
26 (Wath upon Dearne) ...	D. J. Cusiter, M.B., CH.B., D.P.H., D.T.M. AND H.
27 (Doncaster) ...	J. Ferguson, M.B., CH.B., D.P.H.
29 (Thorne) ...	G. Higgins, B.Sc., M.B., CH.B., D.P.H.
31 (Rotherham) ...	J. M. Watt, M.D., CH.B., D.P.H., D.C.H., D.OBST.R.C.O.G.

Assistant County Medical Officers and School Medical Officers—

Division No.

1 (Skipton)	...	...	*Helen M. Dean, M.B., CH.B., D.P.H. *J. A. Farrer, M.B., B.S. Ruth R. Stoakley, M.B., B.CH., B.A.O., D.P.H.
3 (Keighley)	...	...	*Barbara M. Leakey, M.B., B.S. Doreen E. Gledhill, M.B., CH.B.
4 (Shipley)	...	...	*Gwendolen Buckle, M.B., B.S. F. S. Rogers, M.B., CH.B., D.P.H.
5 (Horsforth)	...	...	*G. Firth, M.B., CH.B., D.P.H. *Helen M. Mitchell, M.B., CH.B. Kathleen A. S. Brosnan, M.B., B.CH., D.OBST.R.C.O.G. D.P.H. A. Elsworth, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
7 (Harrogate)	...	...	*Sheila F. Schofield, M.B., CH.B., D.P.H., D.C.H. P. A. G. M. Ashmore, M.R.C.S., L.R.C.P. A. W. I. Hall, M.B., B.CHIR. Gertrude M. Pullan, B.SC., M.B., CH.B., D.OBST.R.C.O.G.
9 (Wetherby)	...	...	Elizabeth M. Hargreaves, M.B., CH.B., D.P.H. Gillian M. Harrison, M.B., CH.B.
10 (Goole)	...	...	Eileen M. R. Bell-Syer, M.B., B.S. Muriel J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H.
11 (Castleford)	...	...	*P. O. Nicholas, M.B., CH.B., D.P.H., D.C.H. J. M. B. Carr, M.B., CH.B.
12 (Pontefract)	...	...	*Gertrude M. Mayhall, M.R.C.S., L.R.C.P. Mercia Obadiah, M.B., B.S., D.OBST.R.C.O.G.
13 (Morley)	...	...	*Barbara Briggs, M.B., CH.B., D.P.H. Irene Hargreaves, M.B., CH.B. Mary K. Sharp, M.R.C.S., L.R.C.P.
15 (Batley)	...	...	Freda M. Cox, M.R.C.S., L.R.C.P. J. E. Lee, M.R.C.S., L.R.C.P.
16 (Rothwell)	...	...	*Ruth M. Bowker, B.A., M.B., CH.B., D.P.H. Sheila M. Dick, L.R.C.P., L.R.C.S.
17 (Spenborough)	...	...	Shirley Jessop, M.B., CH.B., D.P.H. R. Stalker, M.B., CH.B., D.P.H.
18 (Brighouse)	...	...	*Marie P. Milligan, B.SC., M.B., CH.B., D.P.H. D. B. Reynolds, M.R.C.S., L.R.C.P., D.P.H.
19 (Todmorden)	...	...	*Gladys V. Bradshaw, M.B., B.S., D.OBST.R.C.O.G., D.P.H. C. A. Craig, M.B., B.CH., B.A.O., D.P.H.
20 (Colne Valley)	...	...	*D. S. Pickup, M.B., B.S., L.M.S.S.A., D.P.H. *W. P. B. Stonehouse, M.A., M.R.C.S., L.R.C.P., D.P.H. Ethel D. Shaw, M.B., B.CH., B.A.O.
22 (Wortley)	...	...	*Jean J. Smith, M.B., CH.B., D.P.H. F. C. Armstrong, M.B., B.CH., D.P.H. S. Lindsay, M.B., CH.B.
23 (Hemsworth)	...	...	*Edith E. Crompt, M.B., CH.B., D.P.H. Josephine Hayes, M.B., CH.B. Kathleen O'Beirne, M.B., CH.B.
25 (Barnsley)	...	...	*P. H. Brewin, M.B., CH.B., D.P.H. Stella G. A. Henriques, M.B., CH.B.
26 (Wath upon Dearne)	...	...	*Barbara R. A. Demaine, M.B., CH.B., D.P.H. Helen F. Fullwood, M.B., CH.B. Mary R. Menzies, M.B., CH.B., D.C.H.

Assistant County Medical Officers and School Medical Officers—continued

- 27 (Doncaster) Margaret T. Burton, B.A., L.M.S.S.A., L.M.
Christina M. Dornan, M.B., B.CH., B.A.O.
Amy Kropacz, L.R.C.P., L.R.C.S.
- 29 (Thorne) Rose B. Laidlaw-Becker, M.D., CH.B., M.R.C.S.,
L.R.C.P., D.P.H., D.P.M.
- 31 (Rotherham) ... *M. E. O'Neill, M.B., CH.B., D.P.H.
Margaret J. Hallinan, M.R.C.S., L.R.C.P.

100 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 12·4 whole-time Assistant County Medical Officers.

* Senior Assistant County Medical Officer and School Medical Officer.

Chest Physicians—(Joint Appointments with Hospital Services)—

SHEFFIELD REGION

D. H. Anderson, V.R.D., M.D., B.CH., B.A.O., D.P.H.
H. A. Crowther, M.A., M.R.C.S., L.R.C.P.
F. C. N. Holden, M.D., B.S., M.R.C.S., L.R.C.P.
A. C. Morrison, M.D., CH.B., D.P.H.

LEEDS REGION

D. J. Charley, M.D., B.S., M.R.C.P., M.R.C.S.
J. A. Dick, M.B., CH.B.
R. S. Donaldson, M.D., CH.B., D.T.M., D.P.H.
P. A. Duke, M.D., CH.B., D.P.H.
G. F. Edwards, M.B.E., M.B., B.S., M.R.C.P., M.R.C.S.
H. Grunwald, M.D. (VIENNA)
W. D. Hamilton, M.B., B.CH., B.A.O., D.P.H.
W. H. Helm, M.R.C.S., M.R.C.P.
G. Henry, M.B., B.CH., B.A.O.
D. A. Herd, L.R.C.P., L.R.C.S., L.R.F.P.S.
J. W. Jordan, M.D., B.S., M.R.C.P., M.R.C.S.
B. T. Mann, B.SC., M.D., CH.B., D.P.H.
Marjorie S. Oxley, M.B., CH.B., T.D.D.
H. E. Raeburn, M.D., B.S., L.M.S.S.A., D.P.H.
J. K. Scott, M.B., CH.B., M.R.C.P., D.P.H.
D. K. Stevenson, M.B., CH.B., M.R.C.P.
J. Viner, M.B., CH.B.
J. Y. Walker, M.B., CH.B., D.P.H.
R. N. Walker, M.B., CH.B., D.P.H.
A. Weleminsky, M.D. (PRAGUE)

Other Medical Specialists in the School Health Service (Regional Hospital Board and University Appointments)—

OPHTHALMIC

J. Benson, M.B., CH.B., F.R.C.S.
H. C. Black, M.B., B.CH., B.A.O.
S. M. Kamaluddin, M.B., B.S., D.O.M.S.
J. V. Kirkwood, M.B., CH.B., D.P.H.
B. A. Marshall, M.B., CH.B.
A. S. Mather, M.B., B.S.
N. L. McNeill, M.B., B.S., M.R.C.S., L.R.C.P., D.O.M.S.
K. H. Mehta, M.B., B.S., M.R.C.S., L.R.C.P., D.O.
S. Robertson, M.B., CH.B., D.O.M.S.
T. S. Severs, M.D., B.S., M.R.C.S., L.R.C.P.
E. S. Tan, M.B., CH.B., D.O.M.S.
J. L. Wood, M.R.C.S., L.R.C.P.
P. M. Wood, M.B., CH.B., F.R.C.P., D.O.M.S.
L. Wittels, M.D. (Vienna), D.O.

ORTHOPAEDIC

H. N. Burwell, M.B., CH.B.
A. J. S. Bell-Tawse, B.A., M.B., F.R.C.S.
R. W. L. Calderwood, F.R.C.S.
G. F. Hird, F.R.C.S., L.R.C.P.
J. Hunter-Annan, M.B., CH.B., F.R.C.S.
G. Hyman, M.B., CH.B., F.R.C.S.
W. H. Maitland-Smith, M.B., CH.B., F.R.C.S., M.CH.
D. S. Murray, M.B., CH.B., F.R.C.S.
A. Naylor, M.SC., M.B., CH.M., F.R.C.S.
Miss M. A. Pearson, M.B., CH.B., F.R.C.S.
H. Petty, M.B., CH.B., F.R.C.S.
E. R. Price, M.B., B.S., F.R.C.S., M.R.C.P.
J. Wishart, M.B., CH.B., F.R.C.S.

E.N.T.

P. H. Beales, M.B., B.S., F.R.C.S.
W. M. S. Ironside, M.B., CH.B., F.R.C.S.
H. Morus Jones, M.C., M.B., B.S., F.R.C.S., L.R.C.P., D.L.O.
S. Kavanagh, L.R.C.P.I. and L.M., F.R.C.S., D.L.O.
K. M. Mayhall, M.A., M.B., B.CHIR., F.R.F.P.S., M.R.C.S., L.R.C.P., D.L.O.
H. M. Petty, M.B., CH.B., D.L.O., R.C.P.S.
J. E. Rees, M.R.C.S., D.L.O.
W. L. Rowe, M.B., CH.B., F.R.C.S.
C. Smith, M.B., B.S., F.R.C.S., L.R.C.P., D.L.O.

PAEDIATRIC

M. F. G. Buchanan, M.B., CH.B., D.C.H.
G. M. Lewis, M.B., CH.B., D.C.H.
J. D. Pickup, M.D., CH.B., D.C.H.
L. J. Prosser, M.B., CH.B., D.C.H.
R. J. Pugh, M.B., CH.B., M.R.C.P., M.R.C.S.

CARDIAC

L. J. Prosser, M.B., CH.B., D.C.H.
W. S. Suffern, M.B., D.C.H.

DERMATOLOGICAL

W. E. Alderson, M.A., B.M., B.CH.

PSYCHIATRISTS

Winifred M. Burbury, M.B., B.S., M.R.C.S., L.R.C.P., D.P.M.
P. J. Crowley, M.A., M.D., D.C.H., D.P.M.
Elizabeth Gore, M.D., CH.B., D.R.C.O.G., D.P.M.
J. D. Orme, M.R.C.S., L.R.C.P., D.P.M.

NURSING AND MIDWIFERY

County Nursing Officer ...	...	Doris Walker, S.R.N., S.C.M., H.V.CERT.
Deputy County Nursing Officer		Mary G. Edwards, S.R.N., S.C.M. (Part I), H.V.CERT., H.V. TUTOR'S CERT.
Area Nursing Officers ...	...	Gladys Jones, S.R.N., S.C.M., H.V.CERT., Q.I.D.N.S. Winnie Taylor, S.R.N., S.C.M., H.V.CERT., Q.I.D.N.S.
Non-Medical Supervisors of Mid-		Norena M. Everitt, S.R.N., S.C.M., M.T.D.
wives ...	...	Winifred Williamson, S.R.N., S.C.M., M.T.D.
Health Visitor Tutor ...	...	Rona E. Chambers, S.R.N., S.C.M. (Part I), H.V.CERT., H.V. TUTOR'S CERT.

14 Divisional Nursing Officers.
321 Health Visitors and School Nurses (33 part-time).
6 Orthopaedic Nurses and Physiotherapists (4 part-time).
8 Tuberculosis Visitors.
4 Venereal Diseases Social Workers (Qualified Health Visitors).
310 Home Nurses and Home Nurse/Midwives (7 part-time).
187 Midwives (3 part-time).
6 Matrons and 28 other nursing staff at 6 Day Nurseries.

MENTAL HEALTH SERVICE

7 Senior Mental Welfare Officers.
25 Mental Welfare Officers.
1 Trainee Mental Welfare Officer.
Organiser of Training ... Frances E. Woolley, DIP.N.A.M.H.
12 Supervisors in Mental Health Training Centres.
50 Assistant Supervisors and other assistant staff.
12 Home Teachers for (Mentally) Sub-normal Children (2 part-time).

CHILD GUIDANCE SERVICE

Psychologists ... D. G. Pickles, M.A.
H. B. Valentine, M.A.
3 Psychiatric Social Workers (2 part-time).

SPEECH THERAPY SERVICE

Chief Speech Therapist ... Vacancy.
12 Speech Therapists (2 part-time).

DENTAL SERVICE

Chief Dental Officer, Principal D. Davies, M.B., CH.B., B.D.S.

School Dental Officer

Orthodontic Consultant ... Rachel Sclare, DIP.ORTH.R.C.S.(ENG.), L.D.S.

Senior Dental Officers ... W. A. Allen, B.D.S.,
J. M. Enderby, L.D.S.

H. Taylor, L.D.S.

G. A. Thompson, B.CH.D.

School Dental Officers—

I. F. Ash, B.CH.D.

G. H. Bulcock, L.D.S.

Joan M. Davison, L.D.S.

W. H. Dyke, L.D.S.

C. H. Elphick, L.D.S.

P. F. A. Eltome, L.D.S.

J. D. Franks, L.D.S.

Mary M. Gibson, L.D.S.

Kathleen M. Golding, L.D.S.

J. F. Gravely, L.D.S.

M. Hattan, L.D.S.

S. Henry, L.D.S.

Asenath M. Holburn, L.D.S.

F. Kershaw, L.D.S.

S. Levinson, L.D.S.

Valerie P. Lindsay, L.D.S.

F. Lister.

Margaret Lord, B.D.S.

E. S. Midgley, L.D.S.

S. Mitchinson, L.D.S.

Joyce Neden, B.D.S.

D. B. Owen, L.D.S.

G. B. Reid, L.D.S.

Jessie Rothera, L.D.S.

F. H. Sanderson, L.D.S.

S. S. Sanderson, L.D.S.

Susanne E. Schloss, L.D.S.

B. Sleight, B.CH.D.

P. Smith, L.D.S.

Marian M. Thom, L.D.S.

E. Thornton, L.D.S.

P. W. Thornton, L.D.S.

J. Todd, L.D.S.

H. M. Yuile, L.D.S.

24 part-time

Senior Dental Technician J. O. Ford.

7 Technicians.

3 Boy Dental Apprentices.

53 Dental Attendants.

PUBLIC HEALTH INSPECTORS

Chief County Public Health Inspector ... L. Butterworth.

County Public Health Inspector ... D. Greenwood.

ADMINISTRATIVE AND CLERICAL

Chief Clerk G. Richardson, D.P.A.

Sectional Clerks J. H. Milne, D.P.A.

H. Beatson.

T. Myton, D.P.A.

R. S. Marshall.

T. R. Schofield, D.P.A.

W. J. Battye.

Senior Clerk E. Brown.

26 Divisional Senior Clerks

286 Other Clerical Staff

DOMESTIC HELPS

2,324 Domestic Helps (part-time).

ANALYST

County Analyst	...	...	...	R. Mallinder, B.SC., F.R.I.C. (part-time).
Deputy County Analyst	...	...	...	J. C. Harrel, F.R.I.C. (part-time).

PART I

VITAL STATISTICS

Area and Population

Births

Deaths

VITAL STATISTICS

Area and Population:

The area and population of the aggregates of Municipal Boroughs and Urban Districts, Rural Districts, and the Administrative County are appended:—

		Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres)	... ..	380,318	1,226,601	1,606,919
Population:				
Census, 1951	...	1,161,594	426,819	1,588,413
Estimated (mid-1960)		1,187,270	464,690	1,651,960

Number of Municipal Boroughs, 13; Urban Districts, 55; Rural Districts, 21; Total 89.

Summary for 1960:

The live birth rate was 16·9; the still birth rate per 1,000 total births 22; the live premature birth rate per 1,000 live births was 70. The death rate from all causes was 11·5; diphtheria nil; whooping cough 0·001; measles nil; meningococcal infections 0·002; acute poliomyelitis 0·001; tuberculosis, respiratory 0·06; tuberculosis, other forms 0·01; respiratory diseases 1·15; cancer 1·98; heart and circulatory diseases 4·35 per 1,000 population. Infant mortality was 22, and maternal mortality 0·73 per 1,000 total births.

A comparison of the figures for the past 71 years is given in the following table:—

Year	Live Birth Rate	Still Births per 1,000 total births	Death Rates							
			All Causes	Infective and Parasitic Diseases	Tuberculosis, Respiratory	Tuberculosis, Other Forms	*Respiratory Diseases	Cancer	Maternal Mortality per 1,000 total births	Infant Mortality
1890-1909	28·9	†	16·7	1·89	1·19	0·52‡	3·20	0·77‡	†	147
1910-1919	22·5	†	14·5	1·26	0·84	0·41	2·58	0·98	†	112
1920-1929	20·2	†	12·4	0·56	0·68	0·25	2·08	1·20	†	82
1930-1939	15·5	46	12·1	0·30	0·48	0·13	1·24	1·46	4·70	62
1940-1949	18·1	31	12·2	0·16	0·39	0·09	1·43	1·73	1·95	47
1950	16·3	24	11·8	0·10	0·25	0·04	1·18	1·83	0·98	35
1951	15·8	26	12·7	0·10	0·24	0·04	1·48	1·80	0·93	32
1952	15·4	25	11·5	0·07	0·16	0·03	1·11	1·92	0·80	30
1953	15·7	25	11·6	0·08	0·16	0·02	1·20	1·88	0·51	29
1954	15·1	26	11·9	0·08	0·16	0·02	1·16	2·01	0·89	28
1955	15·3	26	11·7	0·07	0·11	0·01	1·17	1·90	0·67	26
1956	16·4	23	11·8	0·07	0·11	0·02	1·22	1·89	0·52	27
1957	16·6	24	11·7	0·07	0·08	0·01	1·22	1·87	0·51	26
1958	16·7	23	11·9	0·05	0·09	0·01	1·29	1·97	0·43	24
1959	16·5	20	11·6	0·04	0·07	0·01	1·26	1·99	0·36	24
1960	16·9	22	11·5	0·06	0·06	0·01	1·15	1·98	0·73	22

* Combined death rate from bronchitis, pneumonia and other respiratory diseases excluding tuberculosis and influenza.

† Figures not available.

‡ This rate is for the 10 years 1900-1909.

Births:

The number of registered live births was 27,935, the resultant birth rate per 1,000 population being 16.9. Still births registered during the year totalled 641 equivalent to a rate of 22.4 per 1,000 total births. Further reference to these vital events appears on page 84.

Deaths:

The total number of deaths allocated to the Administrative County was 18,969 representing a crude rate of 11.5 per 1,000 of the population. This is the lowest rate recorded since 1948 and corresponds to a rate of 11.6 in 1959 and 11.7 in the quinquennium 1955-59.

Due to differing age-sex distribution of the population in areas throughout the country crude death rates, although based on actual occurrences, do not provide an accurate mortality index. To enable more realistic comparisons of the mortality factors operating in one area to be made with those of other areas and with the country as a whole, weighting factors are applied to the crude rates. The death rates from all causes for the past seven years, adjusted by the appropriate factors, for the aggregates of Boroughs and Urban Districts, Rural Districts, the Administrative County, also the rates for England and Wales are given below:—

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1954	12.8	11.4	12.5	11.3
1955	12.7	11.0	12.3	11.7
1956	13.1	12.0	12.9	11.7
1957	12.9	12.0	12.7	11.5
1958	13.3	12.1	13.0	11.7
1959	13.0	11.6	12.7	11.6
1960	12.9	11.9	12.6	11.5

PERINATAL MORTALITY:

This term is used to describe still births together with deaths during the first week of life with the resultant rate expressed per 1,000 live and still births. The 1960 rate of 35.9 is slightly higher than the record low rate experienced in 1959 but compares favourably with all other years for which statistics are available. At ages 1 week up to 1 year the resultant rate was 8.5 per 1,000 total births, the lowest yet recorded. This group mortality is discussed further on page 88.

INFANT MORTALITY:

Deaths of infants under one year totalled 628 which provides an infant mortality rate of 22.5 per 1,000 live births. The rate continues to pursue a downward trend and again is the lowest yet recorded. Details of the cause of death and death rates at various periods in the first year of life are given on page 85.

PRINCIPAL CAUSES OF DEATH:

The most frequent causes, or cause groups, of death were, in descending order, heart and circulatory diseases; malignant neoplasms; vascular lesions of nervous system; diseases of the respiratory system; accidents, suicide and violence. In total these diseases accounted for 16,349 deaths or 86.2 per cent. of the total mortality; their relative frequency during the past five years is indicated in the following table:—

Percentage contribution of five principal cause groups of death to all causes

	1956	1957	1958	1959	1960
Malignant neoplasms	16.0	16.1	16.5	17.1	17.3
Vascular lesions of nervous system ..	15.7	16.8	16.2	15.7	16.1
Heart and circulatory diseases	37.8	36.9	38.5	37.2	37.9
Disease of respiratory system ..	10.9	11.7	11.1	12.4	10.2
Accidents, suicide and violence ..	4.6	4.6	4.6	4.8	4.8

The number of deaths classified according to cause and age appears below:—

Cause of Death	Age at Death — Years								Total
	Under 1 Year	1 and under 5	5 and under 15	15 and under 25	25 and under 45	45 and under 65	65 and under 75	75 and over	
1. Tuberculosis, respiratory	—	—	1	2	10	51	19	18	101
2. Tuberculosis, other	—	1	1	—	2	8	2	2	16
3. Syphilitic disease	—	—	—	—	—	17	13	8	38
4. Diphtheria	—	—	—	—	—	—	—	—	—
5. Whooping cough	1	1	—	—	—	—	—	—	2
6. Meningococcal infections	2	—	—	—	—	—	1	1	4
7. Acute poliomyelitis	—	—	—	—	—	—	1	—	1
8. Measles	—	—	—	—	—	—	—	—	—
9. Other infective and parasitic diseases	6	5	1	—	6	16	10	6	50
Total—Infective & Parasitic Diseases excl. Tub.	9	6	1	—	6	33	25	15	95
10. Malignant neoplasm, stomach	—	—	—	—	10	189	157	164	520
11. Malignant neoplasm, lung, bronchus	—	—	—	1	16	323	166	76	582
12. Malignant neoplasm, breast	—	—	—	—	29	141	71	78	319
13. Malignant neoplasm, uterus	—	—	—	—	15	73	42	22	152
14. Other malignant and lymphatic neoplasms	—	—	—	—	72	523	477	523	1,612
15. Leukæmia, aleukæmia	1	5	4	8	15	28	18	10	88
Total—All forms of Cancer	1	7	13	14	157	1,277	931	873	3,273
16. Diabetes	—	—	—	2	7	41	71	60	181
17. Vascular lesions of nervous system	—	—	—	3	34	473	884	1,654	3,048
18. Coronary disease, angina	—	—	—	1	71	1,096	1,197	1,151	3,516
19. Hypertension with heart disease	—	—	—	—	2	75	131	207	415
20. Other heart disease	1	—	3	5	40	302	545	1,455	2,351
21. Other circulatory disease	—	1	1	—	19	134	202	548	905
Total—Heart and Circulatory Diseases	1	1	4	6	132	1,607	2,075	3,361	7,187
22. Influenza	1	—	1	—	5	6	4	13	30
23. Pneumonia	88	9	4	5	13	70	145	348	682
24. Bronchitis	21	5	2	1	17	289	332	394	1,061
25. Other diseases of respiratory system	6	2	—	3	7	43	55	44	160
Total—Diseases of the Respiratory System incl. Influenza and excluding Tuberculosis	116	16	7	9	42	408	536	799	1,933
26. Ulcer of stomach and duodenum	—	—	—	—	4	49	51	56	160
27. Gastritis, enteritis and diarrhoea	14	2	1	3	5	10	22	21	78
28. Nephritis and nephrosis	1	1	4	7	18	54	43	59	187
29. Hyperplasia of prostate	—	—	—	—	—	6	39	66	111
30. Pregnancy, childbirth, abortion	—	—	—	4	17	—	—	—	21
31. Congenital malformations	132	12	6	2	8	13	2	2	177
32. Other defined and ill-defined diseases	340	20	12	17	59	279	258	508	1,493
33. Motor vehicle accidents	—	13	16	60	53	63	20	16	241
34. All other accidents	11	16	21	17	41	90	56	212	464
35. Suicide	—	—	—	12	35	86	38	21	192
36. Homicide and operations of war	3	2	1	2	—	2	1	—	11
Total—Accidents, Suicide and Violence	14	31	38	91	129	241	115	249	908

TUBERCULOSIS:

Mortality decreased further to a new record low level; there were 117 deaths compared with 138 in 1959 and an annual average of 167 in the quinquennium 1955-59. The corresponding death rates per 1,000 population were 0·07, 0·08 and 0·10 respectively. For a considerable period mortality has progressively declined and whilst setbacks were evident during the two world wars and the years immediately following the second these were merely temporary interruptions in the trend. In recent years the rate of decrease has quickened and suggests that the conquest of the disease is in sight.

Respiratory forms of the disease accounted for 101 deaths representing a death rate of 0·06 compared with 119 (0·07) in 1959 and an annual average of 147 (0·09) in the period 1955-59. Age and sex distribution varied little from that of the previous year with males aged 45 years and over now constituting the crux of this one time scourge. Chemotherapy has made a major contribution in effecting improvements in mortality although other factors, B.C.G. vaccination, mass miniature radiography and better environmental conditions have played their part. In combination these factors have achieved much but their success must not be permitted to engender apathy nor encourage any relaxation of effort towards eradication of the disease.

Deaths from other forms numbered 16, equivalent to a death rate of 0·01 compared with 19 (0·01) in 1959 and an annual average of 20 (0·01) for 1955-59. With the introduction of two further Specified Areas the whole of the Administrative County is covered by such Areas in which the retail sale of milk for human consumption is restricted to that which is pasteurised, sterilised or tuberculin tested. This measure, together with the general scheme of elimination of bovine tubercle in herds, should curtail the risk of infection still further.

INFECTIVE AND PARASITIC DISEASES:

This group comprises the principal epidemic and certain communicable diseases which, in combination, replace the zymotic classification in operation prior to 1950.

Deaths assigned to this group totalled 95 compared with 67 in 1959 and an average of 94 for 1955-59; the equivalent death rates were 0·06, 0·04 and 0·06 respectively.

Compared with the previous year there were reductions in mortality from measles which fell from 6 to nil and meningococcal infections from 6 to 4. Whooping cough (2) and poliomyelitis (1) claimed the same mortality while for the sixth successive year there was no death from diphtheria. The major increase was recorded for syphilitic disease from 25 to 38: this disease continues to be a public health problem but it is satisfactory that for the tenth successive year there has been no death under 1 year. Although deaths from the residual group "other infective and parasitic diseases" increased from 27 to 50 unfortunately the classification of deaths to the individual diseases within the group is not available.

Following the introduction of antibiotics the fatality rate of measles has reduced considerably and in 1960, for the first time, no death was recorded in the Administrative County. The case fatality ratio of meningococcal infections has decreased significantly in the past 30 years or so but it remains the most fatal among the common infectious diseases. Of the deaths 2 were of infants under 1 year which, when related to the 4 notifications at this age, underlines

the need for prompt diagnosis and treatment. The deaths from whooping cough related to a 10 month old baby girl and a boy of 3 years neither of whom had been immunised. The single death from poliomyelitis was of a male aged 66 years; no notification was received, the diagnosis being made following post-mortem examination.

CANCER:

In this group, which includes leukæmia, there were 3,273 deaths, equivalent to a death rate of 1.98 per 1,000 population compared with 3,255 deaths (1.99) in 1959 and an annual average of 3,126 (1.92) for the period 1955-59. In 1960 one death in every six was certified to this group at an average of 63 persons per week. This disease, being associated with middle and old age, can be expected to take an increasing toll in our ageing population for there is, as yet, no indication of the rising trend being arrested.

The number of deaths during the past six years classified according to sex and principal sites is given in the following table:—

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Mal- ignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total all Sites
1955	M.	301	393	2	—	842	46	1,584
	F.	214	72	305	153	684	40	1,468
	T.	515	465	307	153	1,526	86	3,052
1956	M.	298	439	5	—	773	38	1,553
	F.	203	80	272	145	780	33	1,513
	T.	501	519	277	145	1,553	71	3,066
1957	M.	301	473	2	—	832	39	1,647
	F.	216	66	296	144	638	38	1,398
	T.	517	539	298	144	1,470	77	3,045
1958	M.	307	467	2	—	823	57	1,656
	F.	228	82	315	178	721	32	1,556
	T.	535	549	317	178	1,544	89	3,212
1959	M.	318	556	1	—	839	46	1,760
	F.	250	62	263	161	729	30	1,495
	T.	568	618	264	161	1,568	76	3,255
1960	M.	295	505	3	—	905	48	1,756
	F.	225	77	316	152	707	40	1,517
	T.	520	582	319	152	1,612	88	3,273

Since 1956, the relative contribution to mortality made by the separately classified sites has not changed; lung and bronchus was the leading site followed by, in descending order, stomach, breast, and uterus.

The 582 deaths from lung cancer were 36 fewer than in the previous year, but this reduction should not give rise to optimism for indications are that it is merely a temporary fluctuation in the upward trend. Pronounced male excess mortality was again in evidence in the ratio of 7 : 1. The conclusion reached by the Medical Research Council and others that the most incriminating factor is tobacco smoking, particularly in the form of cigarettes, is now widely agreed although research continues on this and the relative contribution made by atmospheric pollution and other factors. It is significant however that 276 deaths representing nearly half the total mortality related to males in the 45-64 years age group.

The number of deaths assigned to malignancy of stomach, breast, and uterus tends to fluctuate from year to year with no trend apparent; leukæmia mortality, however, remains relatively high. The hazard associated with radiation was brought to the forefront following the publication of the Adrian Report and research into causation of leukæmia and appropriate preventive measures continues.

VASCULAR LESIONS OF THE NERVOUS SYSTEM:

Deaths ascribed to this group numbered 3,048, equivalent to a death rate of 11.85 per 1,000 population and constituted 16 per cent. of the total deaths all causes. Although the number of deaths varies slightly each year an upward trend is apparent; indeed, since 1950 mortality has increased by 20 per cent.

Mortality increased progressively with age; at ages under 45 years deaths numbered 37, in the age group 45-64 years 473 (15.5 per cent. of the total deaths from this cause), at ages 65-74 years 884 (29.0 per cent.) and 75 years or over 1,654 (54.3 per cent.). Apart from a slight male excess mortality at ages 45-64 years, there was the usual preponderance of female deaths and this was especially pronounced at ages of 75 years and upwards.

HEART AND CIRCULATORY DISEASES:

Numerically, this group carries the highest mortality, with coronary disease assuming the major role. Deaths in the group totalled 7,187 compared with 7,056 in 1959 and an annual average of 7,165 for the quinquennium 1955-59; the resultant death rates per 1,000 population being 4.35, 4.31 and 4.41 respectively. Closely following the experience of recent years the majority of the deaths were of elderly people; 76 per cent. were aged 65 years or over and 22 per cent. aged 45-64 years. At ages under 75 years there was an excess of male mortality significantly heavy in the 45-64 years age group while at ages 75 years and upwards female deaths predominated.

While fluctuations in mortality from year to year are apt to mask trends in certain diseases the increasing incidence of coronary disease and angina is apparent. This group caused 3,516 deaths, 278 greater than in the previous year and 454 greater than the annual average for 1955-59. As usual there was a male excess of mortality in all age groups which was especially evident at ages 45-64 years; these deaths represented 30 per cent. of the total male mortality at these ages.

In total, deaths ascribed to "other heart disease" again decreased but, as this is a residual group and the component diseases are not separately classified, it is not possible to deduce if significant changes are taking place.

The number of deaths and mortality rates per 1,000 population during the past 6 years appears in the table below:—

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1955	2,721	1.69	503	0.31	2,989	1.86	862	0.54	7,075	4.39
1956	2,960	1.83	471	0.29	2,964	1.83	835	0.52	7,230	4.47
1957	3,024	1.86	433	0.27	2,748	1.69	773	0.48	6,978	4.30
1958	3,367	2.07	508	0.31	2,765	1.70	844	0.52	7,484	4.59
1959	3,238	1.98	413	0.25	2,582	1.58	823	0.50	7,056	4.31
1960	3,516	2.13	415	0.25	2,351	1.42	905	0.55	7,187	4.35

DISEASES OF THE RESPIRATORY SYSTEM:

These causes—influenza, pneumonia, bronchitis, and other diseases of the respiratory system—accounted for 1,933 deaths compared with 2,352 in 1959 and provided a mortality rate of 1.17 and 1.44 per 1,000 population respectively. Deaths from the individual causes were influenza 30 (291 in 1959), pneumonia 682 (790), bronchitis 1,061 (1,111) and other diseases of the respiratory system 160 (160).

It was not an influenza year and no outbreak was reported. The number of deaths fell to the lowest recorded total during the half-century or more that statistics for the disease have been available. The majority of the deaths related to persons aged 65 years or over.

Pneumonia was prevalent during the first quarter of the year and, although continuing as a major cause of death, was a terminal manifestation rather than a primary cause of death in most instances. Mortality was heaviest at the extremes of life; approximately 13 per cent. of the deaths were of infants under 1 year and 51 per cent. of persons aged 75 years or over.

Chronic bronchitis is recognised as a common disabling disease in this country and for some years past in the County mortality has remained relatively stable around 1,100 per annum. The pattern established in recent years was again in evidence, mortality being relatively high in infants under 1 year, negligible at ages to 44 years, thereafter progressively increasing. There was the usual excess male mortality in the ratio of 2 : 1. The death rate from the disease in this country remains among the highest in Europe and, in the present state of medical knowledge, progress in the introduction of smoke control areas seems as likely to effect improvement as advances in medical treatment.

MATERNAL MORTALITY:

A setback was recorded in mortality from the group, pregnancy, childbirth and abortion. In all 21 deaths were recorded, the highest total since 1954, the equivalent death rate per 1,000 live and still births being 0.73. The major increase was occasioned by deaths from abortion and further reference is made on page 89.

VIOLENCE:

There was a slight decrease in the number of deaths from accidents and violence from 919 in 1959, the highest recorded total since 1950 when the revised classification of deaths was introduced, to 908. Deaths from the separately classified causes were motor vehicle accidents 241, other accidents 464, suicide 192, and homicide and operations of war, 11.

Since 1954, with the co-operation of Medical Officers of Health, statistics have been compiled relating to fatal home accidents; the relative frequency of these deaths and others assigned to non-natural causes during the past seven years is indicated in the table appended:—

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	Homicide and Operations of War	Total Accidents, Suicide, Homicide
1954	167	238	236	157	11	809
1955	177	240	267	183	12	879
1956	188	244	258	182	8	880
1957	175	245	228	214	15	877
1958	205	237	256	186	3	887
1959	204	264	252	186	13	919
1960	241	255	209	192	11	908

Deaths from motor vehicle accidents increased to the highest annual total recorded since statistics for this group have been separately classified. The age-sex distribution was similar to that of recent years with the toll heavier among males in the ratio of 3 : 1 and, as usual, the majority of deaths were in the 15-44 years age group. It cannot be emphasised too frequently that these accidents constitute a major problem, indeed at ages 15-24 years 50 per cent. of all male deaths in this age group were caused by motor vehicle accidents.

In comparison with the previous year the number of deaths from other accidents decreased slightly but remain a major cause of disability and mortality. Fatalities in the home far exceed the number of deaths from certain diseases which create apprehension in the minds of the public but perhaps the public alarm is less because the average home accident involves a small group or, more usually, an individual. The total is formidable indeed and propaganda measures are being intensified in an endeavour to achieve reductions.

The principal causes of fatal home accidents are indicated in the following table:—

Cause of Death	Age at Death — Years						
	Under 1	1-4	5-44	45-64	65-74	75 and over	All Ages
Accidental poisoning by solid and liquid substances ... { M. F.	— —	1 1	— 1	2 3	— —	1 2	4 7
Accidental poisoning by gases and vapours ... { M. F.	— —	— —	1 —	6 3	1 4	6 7	14 14
Accidental falls ... { M. F.	— —	1 —	— 2	5 7	11 20	34 89	51 118
Accidents caused by burns and scalds ... { M. F.	1 —	1 1	1 2	3 3	— —	7 8	13 14
Accidental mechanical suffocation ... { M. F.	2 7	2 —	2 —	1 —	1 —	— —	8 7
Other and unspecified accidents { M. F.	— —	— —	2 1	— —	— —	1 1	3 2
Total ... { M. F.	3 7	5 2	6 6	17 16	13 24	49 107	93 162

Seventy-six per cent. of the mortality related to persons aged 65 years or over and, with increasing numbers of people, particularly women, reaching older ages it is unlikely that there will be any halt in the upward trend.

Falls were the prime cause, accounting for 169 deaths equivalent to 66 per cent. of the total fatal home accidents. Females were more vulnerable especially at ages 75 years and over. Nearly 44 per cent. of the total falls were returned as “unspecified” which gives an indication of the high proportion of people who lived alone.

Accidental poisoning by gases and vapours was the second highest contributor with 28 deaths. Old people were most frequently concerned, dying from coal gas poisoning. Temporary loss of memory and impaired sense of smell were probably the underlying causes of many of these tragedies, which emphasise the need for continued research into the production of less toxic domestic gas.

Burns and scalds were the next heaviest cause with 27 deaths. Of the deaths from burns fire was incriminated in 14 cases, gas appliances 3, oil heater 1 and unspecified burns 3. Scalds accounted for 6 deaths of which 3 were sustained in baths.

Fatalities from accidental mechanical suffocation continued at a high level. 15 deaths were reported of which 9 were infants under 1 year, 3 of these were caused by inhalation of food or vomit, 2 from overlaying whilst in bed with their parents and 4 from unspecified asphyxia.

The residual accidental deaths, comprising poisoning by solid and liquid substances 11, electrocution 1, and other accidents 4, remain at a relatively low level.

Suicides numbered 192 compared with the annual average during the period 1955-59 of 190. The distribution of deaths according to age, sex and external agent employed is given in the table below:—

External Agent				Age at Death — Years						
				Under 15	15-24	25-44	45-64	65-74	75 and over	All ages
Domestic Gas Poisoning	...	{	M.	—	3	12	24	8	9	56
			F.	—	3	5	19	11	3	41
Other Poisoning	...	{	M.	—	—	3	7	—	1	11
			F.	—	1	6	6	4	2	19
Hanging or Strangulation	...	{	M.	—	1	3	6	3	1	14
			F.	—	1	1	3	1	—	6
Drowning	...	{	M.	—	—	—	8	5	2	15
			F.	—	—	—	4	3	1	8
Firearms or Explosives	...	{	M.	—	—	2	2	—	1	5
			F.	—	—	—	—	—	—	—
Cutting or Piercing Instruments		{	M.	—	—	—	2	1	—	3
			F.	—	—	—	1	—	—	1
Jumping before Moving Trains		{	M.	—	1	2	2	1	—	6
			F.	—	1	—	1	—	—	2
Jumping from High Places	...	{	M.	—	—	1	1	1	—	3
			F.	—	—	—	—	—	1	1
Other Agents	...	{	M.	—	1	—	—	—	—	1
			F.	—	—	—	—	—	—	—
Total—All Agents	...	{	M.	—	6	23	52	19	14	114
			F.	—	6	12	34	19	7	78

The most frequent vehicle employed was domestic gas; of the total male suicides 49 per cent. used this agent as did 53 per cent. of the total females. Other forms of poisoning, mostly barbiturates and their derivatives, were taken by women more than men but for the remaining agents there was a male excess.

It is recognised that social isolation may be an incriminating factor in the incidence of suicide and although information is not available as to the number of suicides who lived alone 11 of the females were spinsters and 29 of them widows.

CHILD MORTALITY:

Mortality among children aged 1-4 years was slightly higher than in the two previous years. 97 deaths were registered the same as the annual average for the years 1955-59; the equivalent death rates per 1,000 children living in the age group were 0.92.

The table below gives, for certain periods, the number of childhood deaths allocated to the various major causes also the age group death rates:—

Cause of Death		Annual Averages for Quinquennia						1955	1956	1957	1958	1959	1960
		1911-15	1927-31	1935-39	1940-44	1945-49	1950-54						
Measles ... ..	...	439	107	27	18	10	4	4	1	1	—	2	—
Whooping cough ...	...	167	67	29	20	11	5	1	2	—	—	2	1
Diphtheria ... ..	...	110	47	51	32	5	1	—	—	—	—	—	—
Other infective and parasitic diseases, excluding Tuberculosis		54	45	18	13	7	9	7	5	15	5	4	5
Tuberculosis, respiratory	...	47	13	5	4	4	1	—	—	—	—	—	—
Tuberculosis, other	...	201	82	37	39	30	11	3	3	2	—	2	1
Cancer ... ..	...	3	5	4	6	4	9	12	7	10	7	10	7
Heart and circulatory diseases	...	4	3	2	1	1	—	—	1	—	—	1	1
Influenza ... ..	...	6	43	10	11	4	2	—	—	6	2	—	—
Pneumonia ... ..	...	457	321	121	85	42	19	11	14	15	15	11	9
Bronchitis ... ..	...	150	42	10	17	9	6	5	7	5	7	4	5
Other diseases of respiratory system	...	49	15	6	5	3	2	4	1	—	3	1	2
Diarrhoea and other digestive diseases	...	248	45	38	23	17	4	6	2	4	4	4	2
Congenital debility, malformations	...	12	9	7	10	12	13	20	8	10	7	12	12
Accidents ... ..	...	82	54	50	47	38	27	24	30	20	21	19	29
Other causes	...	323	119	52	45	30	23	18	20	12	13	15	23
All causes	...	2,352	1,017	467	376	227	136	115	101	100	84	87	97
Death rate per 1,000 living in the age group ...		17.13	10.62	5.09	4.17	2.23	1.29	1.17	1.05	1.02	0.85	0.86	0.92

Since the turn of the century the progressive improvement in child mortality has been remarkable; the deaths in 1960 were 10 greater than in the previous year but slight fluctuations are to be expected now that mortality at these ages is so low. Further permanent reductions in mortality, although possible, will be difficult to achieve. Loss of child life from infective and parasitic diseases, tuberculosis, respiratory diseases, diarrhoea and many of the less common diseases has reached minimal proportions but it is disappointing that accidental deaths registered an increase. Of these violent deaths 13 were caused by motor vehicles and 7 were attributed to accidents at home.

PART II

DIVISIONAL ADMINISTRATION

DIVISIONAL ADMINISTRATION

By the end of 1959, following the policy of the County Council to reduce the number of divisions as and when the opportunity arises, the number of divisions had been reduced from 31 to 26. During 1960, two further amalgamations, the negotiations regarding which were mentioned in my last Annual Report, and one other amalgamation have now been effected, thus reducing the number of divisions to 23.

The following table gives details of the amalgamations which have so far taken place:—

Div. No.	County Districts	Population Estimated Mid. 1960	Effective Date
20	Colne Valley U. Denby Dale U. Holmfirth U. Kirkburton U. Meltham U.	21,160 9,410 18,730 18,070 5,290	Division No. 20 1st October, 1953
21	Saddleworth U.	16,990	
24	Cudworth U. Darton U. Royston U.	8,960 14,740 8,500	Division No. 25 1st May, 1954
25	Darfield U. Dodworth U. Wombwell U. Worsbrough U.	6,640 4,300 19,160 15,050	
13	Ossett B. Horbury U. Wakefield R.	14,760 8,560 20,540	Division No. 13 1st July, 1955
14	Morley B.	40,330	
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Skipton R.	10,700 5,090 5,360 13,090 23,790	Division No. 1 1st June, 1957
2	Bowland R. Sedbergh R. Settle R.	4,920 3,820 13,920	
5	Pudsey B. Aireborough U. Horsforth U.	33,690 27,840 15,570	Division No. 5 12th September, 1957
6	Ilkley U. Otley U. Wharfedale R.	17,450 11,300 7,140	

Div. No.	County Districts	Population Estimated Mid. 1960	Effective Date
27	Adwick le Street U. Bentley with Arksey U.	18,620 22,320	Division No. 27 1st July, 1960
28	Tickhill U. Doncaster R.	2,570 61,520	
26	Rawmarsh U. Swinton U. Wath upon Dearne U.	19,740 13,020 14,440	Division No. 26 1st November, 1960
30	Conisbrough U. Dearne U. Mexborough U.	17,830 27,370 18,580	
7	Ripon C. Ripon and Pateley Bridge R.	10,290 13,610	Division No. 7 1st April, 1961
8	Harrogate B. Knaresborough U. Nidderdale R.	53,720 9,020 15,560	

By the process of amalgamation there has been a reduction in the number of smaller divisions and there are now four divisions with populations of over 100,000. A comparison of the position prior to the first amalgamation with the present position is as follows:—

<i>Population (Estimated Mid. 1960)</i>	<i>No. of Divisions at the inception of the Divisional Scheme</i>	<i>No. of Divisions as at present</i>
Under 25,000	3	—
25,000-50,000	11	4
50,000-75,000	13	9
75,000-100,000	4	6
Over 100,000	—	4

The following table gives details of each division:—

Div. No.	County Districts	Population (Estimated Mid. 1960)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Bowland R. Sedbergh R. Settle R. Skipton R.	10,700 5,090 5,360 13,090 4,920 3,820 13,920 23,790	2,764 3,519 7,101 4,211 83,327 52,674 152,087 146,071	Dr. M. Hunter Mr. K. A. Knowles Miss F. Stevenson	Water Street, Skipton Tel. Skipton 2438/9
		80,690	451,754		
3	Keighley B.	55,230	23,611	Dr. V. P. McDonagh Mr. A. S. Sanderson Miss J. Butterworth	3, Bow Street, Keighley Tel. Keighley 2244/5

Div. No.	County Districts	Population (Estimated Mid. 1960)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
4	Baildon U. Bingley U. Denholme U. Shipley U.	11,440	2,831	Dr. J. Battersby Mr. F. G. Falkingham Miss M. Tattersall	P.O. Box 24, Town Hall, Shipley Tel. Shipley 51363
		22,090	11,418		
		2,550	2,536		
		31,120	2,184		
		67,200	18,969		
5	Pudsey B. Aireborough U. Horsforth U. Ilkley U. Otley U. Wharfedale R.	33,690	5,323	Dr. A. Telford Burn Mr. A. Hartley Miss D. Topley	The Green, Horsforth Tel. Horsforth 2252
		27,840	6,856		
		15,570	2,706		
		17,450	8,610		
		11,300	2,934		
		7,140	39,378		
		112,990	65,807		
7	Ripon City Harrogate B. Knaresborough U. Nidderdale R. Ripon and Pateley Bridge R.	10,290	1,812	Dr. N. V. Hepple Mr. L. R. Wilkinson Mrs. E. R. Beard	Municipal Offices, Harrogate Tel. Harrogate 5031
		53,720	8,320		
		9,020	2,494		
		15,560	75,009		
		13,610	124,861		
		102,200	212,496		
9	Tadcaster R. Wetherby R.	27,250	72,987	Dr. R. G. Smithson Mr. F. H. Atack Miss G. Jones	Hallfield Lane, Wetherby Tel. Wetherby 2738
		22,780	64,424		
		50,030	137,411		
10	Goole B. Selby U. Goole R. Selby R.	19,540	1,267	Dr. S. K. Appleton Mr. R. Towell Mrs. W. Taylor	6/7, Belgravia, Goole Tel. Goole 936/7
		10,250	3,848		
		9,180	36,776		
		6,790	32,909		
		45,760	74,800		
11	Castleford B. Normanton U.	41,690	4,394	Dr. J. M. Paterson Mr. C. R. Pickering Miss M. E. Thomas	"Castledene," Pontefract Road, Castleford Tel. Castle- ford 4201
		18,600	3,066		
		60,290	7,460		
12	Pontefract B. Featherstone U. Knottingley U. Osgoldcross R.	26,210	4,865	Dr. J. F. Fraser Mr. W. Carver Mrs. W. Taylor	Baghill House, Walkergate, Pontefract Tel. Pontefract 3291
		14,660	4,424		
		11,000	2,835		
		8,140	33,954		
		60,010	46,078		
13	Morley B. Ossett B. Horbury U. Wakefield R.	40,330	9,494	Dr. A. Withnell Mr. A. Wright Miss A. M. Seelig	Windsor House, Morley Tel. Morley 4281/2
		14,760	3,333		
		8,560	1,280		
		20,540	21,344		
		84,190	35,451		

Div. No.	County Districts	Population (Estimated Mid. 1960)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
15	Batley B. Heckmondwike U.	39,750 8,630	4,457 696	Dr. J. F. Caithness Miss K. Lister Miss G. Jones	Market Place, Batley Tel. Batley 666
		48,380	5,153		
16	Garforth U. Rothwell U. Stanley U.	14,380 25,290 17,250	4,020 10,698 4,866	Dr. A. L. Taylor Mr. S. Hobson Miss G. Jones	Oulton Lane, Rothwell Tel. Rothwell 2326/7
		56,920	19,584		
17	Spenborough B. Mirfield U.	36,910 12,260	8,251 3,394	Dr. W. M. Douglas Mr. P. Marshall Miss G. Jones	Elm Bank, Bradford Road, Cleckheaton Tel. Cleck- heaton 2331/2
		49,170	11,645		
18	Brighouse B. Elland U. Queensbury and Shelf U.	30,570 18,490 8,900	7,873 5,946 2,795	Dr. F. Appleton Mr. G. O. Richardson Miss C. J. Barker	Mill House, Huddersfield Road, Brighouse Tel. Brighouse 796
		57,960	16,614		
19	Todmorden B. Hebden Royd U. Ripponden U. Sowerby Bridge U. Hepton R.	17,820 9,570 5,030 17,870 3,960	12,789 7,084 13,289 5,763 21,758	Dr. N. E. Gordon Mr. H. Marshall Miss D. M. E. Goldthorpe	Abraham Ormerod Medical Centre, Todmorden Tel. Todmorden 382
		54,250	60,683		
20	Colne Valley U. Denby Dale U. Holmfirth U. Kirkburton U. Meltham U. Saddleworth U.	21,160 9,410 18,730 18,070 5,290 16,990	16,054 10,165 17,648 13,847 5,906 18,485	Dr. E. Ward Mr. G. A. Beatson Mrs. A. Corless	"Woodville," Scar Lane, Golcar Tel. Milns- bridge 933/4
		89,650	82,105		
22	Hoyland Nether U. Penistone U. Stocksbridge U. Penistone R. Wortley R.	15,890 6,740 10,690 7,440 48,650	1,998 5,593 4,630 29,003 48,698	Dr. J. Main Russell Mr. T. D. Lund Mrs. M. Craig	Mortomley Hall, High Green, nr. Sheffield Tel. High Green 292
		89,410	89,922		
23	Hemsworth U. Hemsworth R.	14,510 52,620	4,163 29,019	Dr. J. S. Walters Mr. G. Ellis Miss S. Willett	Adiscombe House, Barnsley Road, Hemsworth Tel. Hems- worth 377
		67,130	33,182		

Div. No.	County Districts	Population (Estimated Mid. 1960)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
25	Cudworth U. Darfield U. Darton U. Dodworth U. Royston U. Wombwell U. Worsbrough U.	8,960 6,640 14,740 4,300 8,500 19,160 15,050	1,746 2,018 4,717 1,857 1,423 3,838 3,420	Dr. R. Barnes Mr. L. S. Wrigg Miss C. Janse	33 Queen's Road, Barnsley Tel. Barnsley 2247/8
		77,350	19,019		
26	Conisbrough U. Dearne U. Mexborough U. Rawmarsh U. Swinton U. Wath upon Dearne U.	17,830 27,370 18,580 19,740 13,020 14,440	1,593 3,888 1,452 2,602 1,718 2,677	Dr. D. J. Cusiter Mr. P. Goddard Miss V. Dunford	Dunford House, Wath upon Dearne Tel. Wath 2251/2
		110,980	13,930		
27	Adwick le Street U. Bentley with Arksey U. Tickhill U. Doncaster R.	18,620 22,320 2,570 61,520	3,605 4,950 5,580 75,092	Dr. J. Ferguson Mr. W. S. Knivett Vacancy	Station Road, Doncaster Tel. Doncaster 61571
		105,030	89,227		
29	Thorne R.	34,770	38,419	Dr. G. Higgins Mr. J. T. Howitt Mrs. W. Taylor	Council Offices, P.O. Box 4, Thorne Tel. Thorne 3130
31	Maltby U. Kiveton Park R. Rotherham R.	14,080 19,190 59,100	4,788 20,070 28,741	Dr. J. M. Watt Mr. A. Hill Miss F. Keynes	"Edenthorpe," Grove Road, Rotherham Tel. Rother- ham 3131/2
		92,370	53,599		

The standard and extent of accommodation in Divisional Health Offices is a matter which is receiving attention, having particular regard to the additional duties which are being undertaken and to the additional staff, e.g., Mental Welfare Officers, for whom accommodation has to be found. Progress has been made and it is hoped to alleviate the situation still further in the very near future.

It is essential that a scheme of decentralisation should be fully co-ordinated, and to this end monthly meetings of Divisional Medical Officers are held for purposes of discussion and consideration of items which are of topical and general interest. Specific matters requiring detailed consideration are regularly delegated to meetings of three or four Divisional Medical Officers and other persons particularly interested prior to discussion at the monthly meeting.

Co-ordination of effort within the Department is not enough in itself. There must be a link with the general practitioner service, which must be kept informed of the services available, and this has been achieved in the West Riding by the work of the Standing Sub-Committee on Co-operation which is composed of representatives of the general practitioners and of the Health Department. Matters of mutual interest are discussed and their deliberations are made known through the media of the Executive Council and the conferences of Divisional Medical Officers. The following items have been discussed at recent meetings of the Standing Sub-Committee:—

- (a) Ascertainment of Blindness
- (b) Convalescent Homes
- (c) Chiropody
- (d) Diphtheria Swabbing
- (e) Discharges from Hospital—notification
- (f) District Nursing—Use of Iron Dextran by District Nurses
- (g) Health Centres
- (h) Health Visitors—
 - (i) The Health Visiting Service
 - (ii) Duties of Health Visitors
- (i) Major Accidents
- (j) Mental Health—
 - (i) The Mental Health Service
 - (ii) Appointment of Mental Welfare Officers
 - (iii) Relationship between general practitioners and Mental Welfare Officers
 - (iv) Circulation of Practitioners' Guide
 - (v) Approval of practitioners for the purpose of certification
 - (vi) Payment of Fees for Certification
- (k) Midwifery—
 - (i) Issue of Adrenalin to Midwives
 - (ii) Midwives (Amendment) Rules, 1960
 - (iii) Role of Midwife in relation to Blood Tests taken by general practitioners
 - (iv) Trilene
- (l) Routine examination for phenylpyruvic acid
- (m) Rheumatic Fever
- (n) Vaccination and Immunisation—
 - (i) Influenza immunisation
 - (ii) Poliomyelitis vaccination
 - (iii) Immunisation procedures
 - (iv) Immunisation record cards and general practitioners
- (o) Venereal Diseases

PART III

EPIDEMIOLOGY

Notification of Infectious Disease

Vaccination and Immunisation

TUBERCULOSIS

VENEREAL DISEASES

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease:

Smallpox, cholera, diphtheria, membranous croup, erysipelas, scarlet fever and the fevers known by any of the following names, *typhus, typhoid, enteric, or relapsing*, are compulsorily notifiable under Section 144 of the Public Health Act, 1936; *chicken-pox* is notifiable under Section 147 of the same Act in some West Riding County Districts; *food poisoning* under Section 26 of the Food and Drugs Act, 1955. The following communicable diseases are compulsorily notifiable under the regulations stated in parentheses—*measles and whooping cough* (Measles and Whooping Cough Regulations, 1940); *meningococcal infection, acute poliomyelitis—paralytic and non-paralytic, and acute encephalitis—infective and post infectious* (Acute Poliomyelitis, Acute Encephalitis and Meningococcal Infection Regulations, 1949); *ophthalmia neonatorum* (Ophthalmia Neonatorum Regulations, 1926, 1928 and 1937); *puerperal pyrexia* (Puerperal Pyrexia (Amendment) Regulations, 1954); *tuberculosis* (Tuberculosis Regulations, 1952); *malaria, dysentery and acute primary and influenzal pneumonia* (Infectious Diseases Regulations, 1953); *plague* (Notification of Case of Plague (General) Regulations, 1900). *Anthrax* became notifiable as from 1st December, 1960, under the provisions of the Public Health (Infectious Diseases) Amendment Regulations, 1960. The contagious diseases of syphilis, gonorrhoea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.

The following summary shows the number of notifications in 1960 of each notifiable disease, being the number of cases originally notified and the final numbers after revision of diagnosis.

AGE GROUP	FEBRUARY		COUGH		(PARALYTIC)		(NON-PARALYTIC)		ENTERIC OR TYPHOID FEVER		PARATYPHOID FEVERS		ERYSIPELAS		FOOD POISONING	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified ...	765	774	1,583	1,648	3	3	1	1	2,328	2,307	—	—	654	599	17	8
(All ages)	1,539		3,231		6		2		4,635		—		1,253		25	
Final numbers after correction																
Under 1 year ...	6	4	168	158	—	—	—	—	83	88	—	—	37	33	4	—
1—2 years ...	18	16	138	155	1	—	—	—	222	235	—	—	36	30	1	1
2—3 " ...	50	30	195	201	—	—	—	—	257	266	—	—	39	33	—	—
3—4 " ...	72	82	211	188	—	1	—	—	280	295	—	—	44	34	—	—
4—5 " ...	92	90	183	225	—	—	—	—	349	333	—	—	25	25	1	1
5—9 " ...	390	397	611	608	—	1	—	—	1,077	1,022	—	—	105	97	4	4
10—14 " ...	115	134	58	70	—	—	—	—	36	40	—	—	45	44	2	1
15—24 " ...	14	13	4	13	—	1	—	—	7	8	—	—	24	38	2	1
25 and over ...	6	4	10	23	—	1	—	—	5	9	—	—	120	137	1	—
Age unknown ...	1	2	2	6	—	—	—	—	13	11	—	—	3	5	—	—
Total (all ages) ...	764	772	1,580	1,647	2	4	—	—	2,329	2,307	—	—	478	476	15	8
	1,536		3,227		6		—		4,636		—		954		23	
AGE GROUP	ACUTE PNEUMONIA		SMALLPOX		ACUTE ENCEPHALITIS (INFECTIVE)		ACUTE ENCEPHALITIS (POST-INFECTIOUS)		ENTERIC OR TYPHOID FEVER		PARATYPHOID FEVERS		ERYSIPELAS		FOOD POISONING	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified ...	312	222	—	—	6	—	2	2	1	—	1	1	63	72	271	126
(All ages)	534		—		6		4		1		2		135		397	
Final numbers after correction																
Under 5 years ...	61	45	—	—	1	—	—	—	—	—	—	—	1	—	46	25
5—14 " ...	39	25	—	—	1	—	—	—	—	—	—	—	5	1	164	15
15—44 " ...	67	58	—	—	2	—	—	—	—	1	—	—	18	19	28	40
45—64 " ...	89	46	—	—	1	—	—	—	—	—	—	—	24	33	9	19
65 and over ...	52	44	—	—	—	—	—	—	—	—	—	—	15	18	4	5
Age unknown ...	2	2	—	—	—	—	—	—	—	—	—	—	—	2	1	2
Total (all ages) ...	310	220	—	—	5	—	—	—	—	—	—	1	63	73	252	106
	530		—		5		1		—		1		136		358	

The table below affords a comparison with the preceding eight years:—

Disease	Number of corrected notifications									
	1952	1953	1954	1955	1956	1957	1958	1959	1960	
Scarlet Fever
Whooping Cough
Acute Poliomyelitis (paralytic)
Acute Poliomyelitis (non-paralytic)
Measles
Diphtheria
Dysentery
Meningococcal Infection
Acute Pneumonia (primary or influenzal)
Smallpox
Acute Encephalitis (infective)
Acute Encephalitis (post-infectious)
Enteric or Typhoid Fever (excluding Paratyphoid)
Paratyphoid Fevers...
Erysipelas
Food Poisoning
Ophthalmia Neonatorum
Puerperal Pyrexia
Tuberculosis:
Respiratory
Other Forms
*Chicken-pox
†Malaria
†Anthrax

*Chicken-pox is compulsorily notifiable only in certain County Districts, and the figures given do not, therefore, represent the full number of cases occurring in the Administrative County.

†All the cases of malaria shown in the above table were believed to be contracted abroad.

‡Anthrax became notifiable from 1st December, 1960.

Vaccination and Immunisation:

With the availability of a wide range of antigens and vaccines, some for use as a single agent, some in combined and some in triple form, a somewhat complex situation arose and it became clearly desirable that some policy should be advocated from County level. An Antigen Working Party, comprised of the Central Office medical staff and representatives of the Divisional Medical Officers, was therefore set up.

This Committee gave very careful consideration to the advantages and disadvantages of a programme based on single antigens as against a programme based on triple antigens, with special reference to the alternative schedules as given in the report of the symposium on "Immunisation in Childhood" which appeared in the British Medical Journal on 23rd May, 1960.

The Committee came to the conclusion that, on balance, there are undisputed administrative and personal advantages by recommending the adoption of a programme based on the use of triple antigens. The following programme was, therefore, drawn up and approved by the Conference of Divisional Medical Officers:—

<i>Age</i>	<i>Vaccine</i>	<i>Interval</i>
2-6 months	Triple (Diphtheria, Tetanus, Pertussis)	
	Ditto	4 weeks or more
	Ditto	Ditto
6-9 months	Poliomyelitis	Ditto
	Ditto	Ditto
15-18 months	Ditto	
18-24 months	Smallpox Vaccination	
School entry	Diphtheria and Tetanus (Booster)	
10 years (approx.)	Ditto	
	The Diphtheria booster at 10 years is a matter for individual decision by the Medical Officer in view of the low level of recorded positive Schick tests at that age (which is about 5%)	
13 years (approx.)	B.C.G.	

After the adoption of this programme, the Committee held a further meeting to consider some queries which had arisen as to the combination of tetanus immunisation with the diphtheria booster dose. There was also the question as to which antigen (F.T. or T.A.F.) was best for the diphtheria booster dose, one Divisional Medical Officer having reported a few fairly severe reactions when using Formal Toxoid with children over 10 years of age. In view of these reports the Committee considered the advisability of Schick testing the older children who were due for diphtheria immunisation booster doses. The Committee finally submitted the following recommendations and these were also accepted by the Divisional Medical Officers' Conference.

1. RECOMMENDATIONS FOR TETANUS (PRIMARY AND BOOSTER) AND DIPHTHERIA RE-IMMUNISATION IN SCHOOL CHILDREN

- (a) That routine Schick testing is not practicable.
- (b) That the decision as to the choice of antigen (T.A.F. or F.T.) be left to the discretion of the medical officer, in the light of experience.
- (c) That the second diphtheria booster dose should preferably be given before the age of ten years, to avoid a high incidence of reactions.

2. TETANUS IMMUNISATION

- (a) That primary immunisation against tetanus be offered at the same time as the diphtheria booster doses.
- (b) That the child aged 5-9 years, not previously protected against either diphtheria or tetanus, should receive three injections of diphtheria/tetanus antigen at appropriate intervals, i.e., intervals of not less than four weeks between first and second, and approximately 12 months between second and third.
- (c) That the child (normally aged 5-9 years) who has had primary immunisation against diphtheria but not against tetanus, and who requires a diphtheria booster dose should receive—

<i>First Injection</i>	<i>Second Injection</i>	<i>Third Injection</i>
Tetanus only (intervals as in (b) above).	Diphtheria/Tetanus combined.	Tetanus only

NOTE.—The combined diphtheria/tetanus should not be given as the first injection of this series.

The programme of immunisation, as agreed, is now included on a personal Immunisation Record Card, which provides space for recording each injection given as well as the date of the next appointment. It is retained by the parent but presented for endorsement to the general practitioner or clinic doctor when further injections are given. A note on the card emphasises the importance of producing the record in cases of illness or accident. This is especially important where tetanus immunisation has been given, since it could obviate the need for administering A.T.S. (anti-tetanic serum), which is known to produce reactions, occasionally severe, in some allergic individuals. The antigen used for non-emergency routine immunisation, viz. tetanus toxoid, is, on the other hand, entirely innocuous. The card is provided with a transparent protective cover large enough to hold the child's personal medical card. It has had an enthusiastic reception with both County medical staff and general practitioners.

TETANUS IMMUNISATION:

The number of children who received protection against tetanus during 1960 is as follows:—

<i>Age at final injection</i>			
Under 6 months ...	...	5,306	
6 months—1 year ...	...	9,170	
1—2 years ...	...	3,367	
2—3 years ...	...	887	
3—4 years ...	...	745	
Over 4 years ...	...	2,823	
Total ...		22,298	

Scarlet Fever:

Corrected notifications decreased markedly to 1,536 compared with 2,441 in 1959 and an annual average of 2,025 in the decennium 1950-59. Even so, the incidence per 1,000 population of 0·93 was appreciably higher than that of England and Wales, 0·70. Notifications were most numerous in young children; 29·9 per cent. were at ages under 5 years and 51·2 per cent. aged 5 to 9 years. The seasonal incidence followed the pattern of former years being highest in winter with a marked recession during the summer.

In recent years, scarlet fever as a clinical entity can fairly be described as a mild illness which is amenable to treatment. Save for exceptional cases, hospitalization is not necessary and fatalities are rare.

Whooping Cough:

During the period 1956 to 1959 notifications progressively declined to the record low total of 953; in 1960, however, they increased to 3,227.

A departure from the usual greater prevalence in the spring months was a period of high incidence during May to September with a peak of 163 notifications during the week ended 2nd July. During that period, 1,976 notifications were made, twice the annual total for 1959.

Age-sex incidence closely followed the experience of post-war years; 10·1 per cent. of the cases related to infants under 1 year, 46·4 per cent. in the 1-4 years age group and 37·8 per cent. aged 5-9 years with slightly higher incidence among females.

IMMUNISATION AGAINST WHOOPING COUGH:

Whooping Cough vaccine has been available to the Authority's medical officers and to general practitioners throughout the year either as a single antigen or in combination with the diphtheria and/or tetanus antigens, the choice being left to the discretion of the individual doctor. The demand for the triple vaccine has rapidly increased and now exceeds by far the demand for the single or combined antigens. This is partly the result of the recommendations of our Antigen Working Party.

During the year, 20,772 children received a full course of immunisation against Whooping Cough and since facilities were introduced in 1952 a total of 108,007 children have been immunised under the Authority's scheme. Sixty-seven thousand two hundred and fifty-seven of these are in the age group 0—4 years inclusive, representing 51·0 per cent. of the total population in this age group.

Of the 3,169 notifications of Whooping Cough in the 0—14 year age group, only 421 concerned children who had been immunised against this disease. Two deaths from Whooping Cough were notified, one aged under one year and the other aged three years, and in neither case had the child been immunised.

Poliomyelitis:

After revision of diagnosis only six of the notified cases of poliomyelitis were confirmed, all of the paralytic form. This total represents the lowest incidence recorded since the disease became of major importance in this country in 1947. All were sporadic cases with no connection apparent. Each case was meticulously investigated and various details are appended.

Case 1 was of a 3 year old girl who had received 3 injections of poliomyelitis vaccine. Various diagnoses were considered but finally after some months and in spite of the absence of virological confirmation we were left with the clinical view that it was most likely a case of paralytic poliomyelitis. The degree of residual paralysis was slight.

The second case was an unvaccinated 39 year old woman. She had bilateral adductor involvement of the thighs and legs plus some involvement of one forearm. Following discharge from hospital she had a course of physiotherapy and has no residual disability.

Case 3, an unvaccinated boy of 16 months, developed facial paralysis and was confirmed as suffering from poliomyelitis.

The next case was of a 5 year old girl, who had been triply vaccinated against poliomyelitis. The diagnosis was in doubt for three months; she had a mild illness towards the end of March and later complained of pain in one leg when her parents noted loss of movement; admission to hospital was arranged and on 23rd May some muscular wasting was noted. Subsequently the child was transferred to another hospital on 15th July and it was only then that a possible diagnosis of poliomyelitis was mentioned. There was a fair degree of residual paralysis in the left leg but the child is able to get about reasonably well and has entered a primary school.

In case 5, a 17 year old female who had had 3 injections of poliomyelitis vaccine, the onset of the disease was atypical, the diagnosis of peripheral neuritis being considered. She had however a moderate degree of paralysis of left leg. The glutei, hamstring and gastrocnemius muscles were almost completely paralysed and it seems likely that she will be left with some degree of disability.

A boy aged 3 who had been triply vaccinated against poliomyelitis was taken ill whilst on holiday and, on return home, was admitted to hospital. Subsequently the diagnosis of poliomyelitis was made. The muscle groups affected were the gluteus maximus, the quadriceps and the adductors. The right lower limb only was affected, the spine and upper limbs being normal. He made good progress and at the year end he had only a slight residual weakness for which he was receiving physiotherapy.

The exceptionally low incidence of the disease in 1960 is probably at least partly attributable to the effectiveness of poliomyelitis vaccination. This view is supported by evidence accumulated by the Medical Research Council. There is therefore every hope that this disease will remain under control.

VACCINATION AGAINST POLIOMYELITIS:

On 1st February, 1960, the Minister of Health authorised a further extension of the arrangements for vaccination against poliomyelitis by raising the upper age limit to include all persons who, at the time of their application, had not reached the age of forty. Prior to this the offer of vaccination against poliomyelitis was, apart from persons in the priority groups, confined to children and young people born on or after the 1st January, 1933. This extension of the scheme did not produce a great rush of applicants and it was easily absorbed within the already well-established machinery for dealing with poliomyelitis vaccination.

The raising of the age limit to forty represented the last general extension of the scheme so far as local health authorities are concerned, but in December the Minister of Health announced that as from 1st January, 1961, vaccination against poliomyelitis would be available to all. In making this announcement the Minister of Health made it clear that the approved arrangements of local authorities for the vaccination of persons up to 40 years of age, and of certain persons subject to special risk would continue as heretofore, but that the vaccination of persons outside these groups would be done through the general practitioner service.

The tremendous public response of 1959 was not repeated during 1960 and although the campaign was pursued with no relaxation of effort the tempo was calmer than in the previous year and the number vaccinated was not quite so spectacular. Nevertheless a great deal of good work was done, much of it being a consolidation of the previous year's efforts, as instanced by the fact that no less than 140,433 persons received their third injection—many of these were young people who had received first and second injections during the early summer of 1959.

The scheme for the provision of evening sessions, approved by the County Council in 1958, was again a great boon and enabled the medical and nursing staff to deal with a large number of applicants without undue interference of their other duties.

The total number of poliomyelitis injections given during 1960 was 266,143 of which 35,817 were given at evening sessions.

By the end of the year 321,046 children under seventeen had been vaccinated with two injections, and a further 4,946 had received their first injection of poliomyelitis vaccine. In the 18-26 years age group, 92,453 young people have been protected and in the 27-40 years group the number was 17,847. The number of persons (all groups) who have received a third injection now totals 363,646.

There has been an ample supply of British vaccine throughout the year.

Measles:

The incidence followed its usual biennial periodicity, the number of cases showing a sharp decline compared with that of 1959, an epidemic year. By September, 1959, the epidemic was over and notifications remained low until the last quarter of 1960. During that quarter, 2,907 cases were notified, representing 62·7 per cent. of the annual total. This was the build-up for the peak which was anticipated would be reached in the spring of the following year.

Measles is one of the most infectious diseases and few children escape much beyond their entrance to school without contracting the illness; indeed, 52 per cent. of the notifications were of children under 5 years.

Fortunately, by far the majority of cases are mild and, as indicated in the following table, fatality ratios recently have reached almost negligible proportions, in fact 1960 was the first year in which no death was recorded in the Administrative County.

Year	Number of notifications	Number of deaths	Fatality Ratio (deaths per 100 notifications)	Year	Number of notifications	Number of deaths	Fatality Ratio (deaths per 100 notifications)
1947	21,739	34	0.16	1954	5,558	3	0.05
1948	16,545	15	0.09	1955	29,357	4	0.01
1949	16,489	18	0.11	1956	3,281	1	0.03
1950	15,763	9	0.06	1957	28,352	5	0.02
1951	25,194	17	0.07	1958	6,183	1	0.02
1952	13,938	7	0.05	1959	24,480	6	0.02
1953	19,853	9	0.05	1960	4,636	—	—

Diphtheria:

After setbacks in 1958 and 1959 when respectively there were 2 and 3 cases it is satisfactory being able to report that no notification was received.

There is however no room for complacency for outbreaks elsewhere in the country indicate that there is still a hard core of infection. Many parents of to-day have never known the seriousness of the disease or the tragedies for which it was responsible, consequently there is some degree of apathy to be overcome. Immunisation is the only means of preventing the disease and every effort is made to raise the immunisation state to the highest level.

DIPHTHERIA IMMUNISATION:

The number of children who received immunisation during 1960, together with figures for previous years, are shown in the following table:—

Year	Number of children who completed a full course of immunisation			Number of children who were given a reinforcing injection
	Under 5	5—14	Total	
1948	20,958	6,220	27,178	19,274
1949	20,728	7,162	27,890	18,071
1950	14,836	3,961	18,797	13,929
1951	16,606	5,567	22,173	17,092
1952	15,798	5,298	21,096	23,390
1953	13,768	4,893	18,661	22,614
1954	15,207	5,013	20,320	22,515
1955	13,566	4,516	18,082	18,663
1956	14,874	4,367	19,241	18,130
1957	15,032	4,803	19,835	15,034
1958	17,273	2,368	19,641	9,541
1959	20,162	2,892	23,054	14,852
1960	23,351	5,363	28,714	21,653

There has been a welcome increase in the number of children who have completed a primary course of immunisation, whilst the increase in the number who received a reinforcing injection is quite considerable. The upward trend in the number of children who received immunisation before their first birthday continued, and the following table shows the encouraging progress which has been made in this age group during recent years.

Children immunised before first birthday

*Percentage of
population
in age group*

<i>Year</i>	<i>Number Immunised</i>	
1955	1,781	7.5
1956	2,623	10.0
1957	9,189	36.0
1958	11,269	42.0
1959	13,732	51.2
1960	17,511	65.8

The ultimate aim is to immunise at least 75 per cent. of children before they attain their first birthday.

The following table gives details of the immunisation state at the end of the year of the child population 0—14 years inclusive, compared with previous years:—

Number Immunised

Year	Under 5	Percentage of population under 5	5—14	Percentage of population 5—14	Total under 15	Percentage of population under 15
1948	59,795	44.1	139,194	65.0	198,989	56.9
1949	64,811	46.7	143,966	65.8	208,777	58.4
1950	66,484	47.9	150,179	67.1	216,663	59.7
1951	66,077	47.4	150,177	70.1	216,254	61.5
1952	60,885	46.4	177,875	74.8	238,760	64.7
1953	54,304	42.9	198,151	81.4	252,455	68.2
1954	55,990	45.2	217,052	87.5	273,042	73.4
1955	53,180	43.6	224,126	88.3	277,306	73.8
1956	53,147	43.6	233,120	90.2	286,267	75.2
1957	54,572	44.1	231,100	89.2	285,672	74.6
1958	58,457	46.4	226,593	87.3	285,050	73.9
1959	64,878	50.5	219,178	85.1	284,056	73.6
1960	73,078	55.4	226,566	88.5	299,644	77.3

Dysentery:

For the second consecutive year the number of notifications decreased, the total of 954 comparing favourably with 1,169 in 1959 and the average of 1,811 for the five years 1955-59. As will be seen from the table appended the incidence was highest in the first quarter but, thereafter, contrary to the usual experience, notifications were progressively lower quarter by quarter.

		Male	Female	Total	Percentage of Annual Total
First Quarter	..	149	186	335	35.1
Second Quarter	..	131	108	239	25.0
Third Quarter	..	100	98	198	20.8
Fourth Quarter	..	98	84	182	19.1
		<hr/>	<hr/>	<hr/>	<hr/>
Total	..	478	476	954	100.0
		<hr/>	<hr/>	<hr/>	<hr/>

Notifications by sex and age groups during the past five years were as under:—

	Males				Females				Persons			
	All ages	0—	5—	10+	All ages	0—	5—	10+	All ages	0—	5—	10+
1956	1,432	381	440	611	1,253	318	383	552	2,685	699	823	1,163
1957	733	245	215	273	644	209	142	293	1,377	454	357	566
1958	1,236	380	421	435	1,277	361	387	529	2,513	741	808	964
1959	597	191	168	238	572	173	146	253	1,169	364	314	491
1960	478	181	105	192	476	155	97	224	954	336	202	416

The usual tendency of the disease to be prevalent in pre-school and primary school children was again in evidence. So too was a male excess at ages under 10 years.

Since notification commenced in 1919 the character and incidence have undergone various changes. By far the majority of cases in recent years have been of the Sonne variety which is generally mild with a low fatality rate.

The generally accepted modes of transmission of Sonne dysentery are direct and indirect contact, with the symptomless excreter also contributing to a lesser degree. Ample evidence has accumulated to support the view that contamination of food, food utensils and dust are all secondary to defective personal hygiene. The practice of young children infecting their hands at visits to the toilet then transferring the infection endorses the need for good hand hygiene. Only careful attention to personal cleanliness and above all the simple yet effective measure of thoroughly washing the hands after each visit to the W.C. will prevent its dissemination.

Commenting on an outbreak in Heckmondwike U.D., Dr. Caithness, the Medical Officer of Health, writes:—

“ The first cases were brought to my notice by the Headmistress of an Infants School on the 14th and 15th March, as from 8 to 10 children were absent from school with symptoms of diarrhoea and/or vomiting. On the 15th March, two cases of dysentery were notified by a General Practitioner in respect of a father and five year old son. With regard to the father it was found that this man was employed in a food store in Bradford. The Medical Officer of Health of Bradford was immediately notified and at his request was kept informed of the progress of laboratory specimens.

Investigations were made of children at the Infants School and faeces reports showed the illness to be Sonne dysentery. In all cases where positive report was received in respect of a child, specimens were then obtained from the rest of the family and a large number of positive cases reported were discovered in this way. In at least three families of four to six children, visits by the Public Health Inspector revealed that other children, some of them of pre-school age, were already showing symptoms.

Immediately after the first visit to this school, arrangements were put in hand for hand-dipping by the children and paper towels were requisitioned and in use throughout the outbreak. The hand-dipping technique consisted of a bowl of quaternary ammonium disinfectant solution being placed beside the wash-basins, together with nail brushes and children were instructed to use this on arrival at school, at playtime, and after all visits to the toilet.

On a subsequent visit to the Infants School at the end of March, the Register showed 15 absentees out of a roll of 104, which is not unremarkable in an Infants School at this time of the year."

Meningococcal Infection:

The number of corrected notifications and deaths since 1950 are given below:—

Year	Number of notifications	Number of Deaths	Fatality Ratio (Deaths per 100 notifications)
1950	55	14	25.5
1951	57	13	22.8
1952	50	6	12.0
1953	37	12	32.4
1954	41	15	36.6
1955	39	10	25.6
1956	71	9	12.7
1957	64	13	20.3
1958	48	7	14.6
1959	30	6	20.0
1960	23	4	17.4

Notifications declined again to the lowest total since 1950 when this infection was made notifiable. Previously, when "cerebro-spinal fever" was notifiable although not strictly comparable, notifications have not been so low since 1938. Incidence remained comparatively high at younger ages with only 7 cases arising in persons aged 10 years or over.

The infection continues to be one of the residual problems in the control of infectious disease, although modern treatment is usually effective, providing an early diagnosis is made.

Smallpox:

For the seventh successive year no case of smallpox was reported in the Administrative County. Absence of the disease must not be allowed to foster apathy for there remains the continuous risk of re-invasion from the many endemic foci in the world. The increase in travellers abroad and the frequent movement of the disease across international boundaries underlines the need to secure and maintain a high proportion of persons protected by vaccination.

VACCINATION AGAINST SMALLPOX:

Vaccination was offered to the parents or guardians of all children during the early months of life, but after considering the whole question of vaccination and immunisation of children against a number of diseases, it has been decided to offer vaccination against smallpox to children between the ages of 18 and 24 months. The reduction in the number of vaccinations in the age group "under one" and the apparent fall in the vaccination rate to 24.55 per cent. when related to the 27,935 registered live births during 1960, as compared with the corresponding figures of 35.36 and 33.75 per cent. for 1959 and 1958, is no doubt due to this postponement of the age for vaccination.

The following table shows the number of vaccinations and re-vaccinations performed during the years 1957-60:—

Vaccinations							Re-Vaccinations						
Year	Under 1	1	2-4	5-14	15 or over	Total	Under 1	1	2-4	5-14	15 or over	Total	
1957	8,335	795	505	414	798	10,847	10	14	86	262	1,498	1,870	
1958	9,213	1,009	477	393	669	11,761	45	7	50	200	1,299	1,601	
1959	9,563	909	431	365	751	12,019	5	7	56	175	1,237	1,480	
1960	6,857	946	480	419	780	9,482	2	5	39	212	1,264	1,522	

One case of generalised vaccinia was reported during the year. The patient was under six months of age at the time of vaccination. The illness was mild and recovery was uneventful.

Acute Encephalitis:

Six notifications were confirmed; five infective and one post-infectious. All the infective cases were males but there was no apparent connection. Cases of the post-infectious form are usually associated with one of the commoner virus infections; the case referred to, a five year old girl, followed an attack of mumps.

Enteric Fevers:

TYPHOID FEVER:

For notification purposes the distinction between typhoid and paratyphoid fevers was not officially made until 1941. Since that time the annual number of notifications of typhoid fever has fluctuated within the range of nil to 27; in 1960 no case was confirmed.

Whilst the disease would appear to be a decreasing hazard in this country the risk remains of importation by persons contracting the infection abroad.

PARATYPHOID FEVERS:

Only one case was notified, a 15 year old girl, and in spite of intensive investigations the source of the infection was not discovered.

Food Poisoning:

Where reference is made to notified or ascertained cases of food poisoning the following definitions apply:—

A family outbreak comprises two or more cases confined to members of the same family.

Other outbreaks relate to two or more connected cases in persons of different families.

A single or sporadic case is one which was not, so far as could be ascertained, connected with other cases or excretors.

Information as to the incidence of food poisoning has been obtained from the statutorily notified cases and the reports of Medical Officers of Health on outbreaks and associated investigations. Notifications numbered 358 and a further 305 cases were ascertained during the course of investigations, resulting in a total of 663 incidents compared with 322 incidents in 1959, 186 in 1958 and an annual average for the period 1955-59 of 417. The microbial causes are shown in the table:—

Food poisoning, all types—outbreaks, family outbreaks and sporadic cases
by presumed causes

Presumed Causal Agent	Family Outbreaks		Other Outbreaks		Sporadic Cases	Total Cases
	Number	Cases Involved	Number	Cases Involved		
Salmonella Typhi-murium	4	17	—	—	67	84
Other Salmonellæ	4	9	1	32	36	77
Cl. Welchii	—	—	5	393	1	394
Staphylococci	—	—	1	3	7	10
Other Organisms	—	—	—	—	8	8
Not discovered	—	—	—	—	90	90
All agents	8	26	7	428	209	663

Although the number of incidents increased the general picture resembled that of previous years.

Outbreaks due to *Cl. Welchii*, though few in number, often involve large numbers of cases. The five outbreaks reported comprised 110, 43, 11, 158 and 71 cases. Usually these outbreaks are due to or are associated with inadequately cooked or re-heated meat or meat products with poor storage facilities, lack of refrigeration and unsatisfactory kitchen hygiene contributory factors. That infection by *Cl. Welchii* ceases to be a hazard if correct cooking technique, refrigeration and kitchen methods are employed is endorsed in the following summary by Dr. Hunter reporting on an outbreak at a private school in Division 1:—

“Minced meat, bought from the local butcher, was supplied to both senior and preparatory schools and was cooked for lunch that day. Some of the minced meat was left over from lunch and maintained at what was described as ‘blood heat’ until being served to some of the senior boys for high tea some five hours later.

Of the 250 at risk, 43 senior boys were affected, which is a very small number if it was the luncheon mince which was infected. They had abdominal pain and diarrhoea of short duration commencing 11 to 13 hours after high tea. The other meals served on the day did not give rise to suspicion. All investigations incriminated the mince, left over from lunch, which had been maintained at the optimum temperature for bacterial growth.

This school (senior boys’ department) also had an outbreak of food poisoning due to *Cl. Welchii* earlier in the year when 110 persons were affected. On that occasion too the fault lay in the preparation of a meat dish.”

The number of incidents involving *Salmonellæ* approximated to that of the previous year and again the foods responsible were seldom identified conclusively. The source and mode of spread of salmonella infections remain by far the greatest problem; egg and egg products, meat, feeding stuffs and fertilisers continue to be under suspicion and studies into the sources of contamination of both animal and human foods are being maintained.

Carelessness contributes much to the incidence of food poisoning. Statutory powers under the Food Hygiene Regulations strengthen the hands of the Medical Officers of Health and their staffs but the dissemination of the disease could be considerably reduced if high standards of kitchen and personal hygiene were practised by all persons engaged in the preparation and handling of food.

Ophthalmia Neonatorum:

In the Ophthalmia Neonatorum Regulations the disease is defined as “a purulent discharge from the eyes of an infant commencing within 21 days from the date of its birth.” Should cases arise it is imperative that treatment should be administered promptly if impaired vision or total blindness is to be prevented. Since 1950 the number of notifications has fallen considerably; in 1960 only 5 cases were notified, each case responding to treatment with no impairment of vision.

Puerperal Pyrexia:

In 1951, revised Regulations were introduced defining puerperal pyrexia as “any febrile condition occurring in a woman in whom a temperature of 100·4°F. (38°C.) or more has occurred within fourteen days after childbirth or miscarriage.” Since then notifications have averaged 107 per annum compared with 61 in 1960.

Anthrax:

According to the Report of the Committee of Inquiry on Anthrax (Ministry of Labour, November, 1959) the disease in humans is almost exclusively an occupational disease in this country and approximately five-sixths of recorded cases arise in the course of employments coming within the provisions of the Factories Acts.

In addition, certain sources of anthrax are to be found outside the purview of the Factories Acts, notably bone meal and allied products which may give rise to anthrax in the farm worker or gardener. Subsequently the Committee's recommendations that the disease should be made notifiable under the Public Health Act, 1936, while retaining the existing arrangements whereby industrial anthrax is notifiable also to the Factories Inspectorate, were embodied in the Public Health (Infectious Diseases) Amendment Regulations, 1960, which came into operation on 1st December.

Procedures for referring all cases of suspected anthrax for immediate medical advice were established in all factories, warehouses and docks where materials with an anthrax risk are handled. Additionally, with the co-operation of the Factory Inspectorate and the Regional Hospital Boards, lists of firms and factories handling the materials with an anthrax risk also the hospitals to which suspected cases could be sent for diagnosis were prepared and issued to Medical Officers of Health and General Practitioners.

During December, two cases were confirmed. The first, a farm worker who had a typical cutaneous lesion on a finger which responded to massive doses of penicillin and cleared up within a week. The Divisional Veterinary Officer of the Ministry of Agriculture, Fisheries and Food also made investigations but was unable to find evidence of infection among the farm animals and we were left with the suggestion that the infection may have been acquired from some old harness on the premises.

The other case was employed as a waste wool shaker at a firm of yarn spinners. Raw wool used in the mill was obtained from many countries including New Zealand, Australia, South Africa, India, Pakistan and the British Isles. Investigations were made by the Inspector of Factories; the source of infection, however, remained untraced. The man had a cutaneous lesion on the back of his neck for which he received out-patient treatment at a local hospital and at the year end was making satisfactory progress.

Influenza:

The disease is not statutorily notifiable and the most reliable index of morbidity remains the variations in the weekly returns of new claims to sickness benefit as issued by the Ministry of Pensions and National Insurance supplemented by information regarding school absenteeism, notifications of pneumonia and deaths attributed to influenza.

Incidence remained low throughout the year and up to the year-end there was no indication of the widespread outbreak which was to occur in the first quarter of 1961.

TUBERCULOSIS

Deaths from Tuberculosis:

There were 117 deaths from tuberculosis (101 respiratory and 16 non-respiratory), representing a death rate of 0·07 (0·06 respiratory and 0·01 non-respiratory), which corresponds with the England and Wales death rate of 0·07 (0·07 respiratory and 0·01 non-respiratory). Details of deaths are given in the following table:—

Classification	Age at Death in Years																Total		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75—				
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Respiratory ...	—	—	—	—	—	1	1	1	7	3	46	5	18	1	15	3	87	14	101
Non-respiratory	—	—	1	—	1	—	—	—	1	1	6	2	1	1	2	—	12	4	16
Totals ...	—	—	1	—	1	1	1	1	8	4	52	7	19	2	17	3	99	18	117

Notification of Tuberculosis:

There were 592 primary notifications of tuberculosis arising during the year and 30 supplemental notifications, a total of 622 as compared with 742 (721 primary and 21 supplemental) notifications in 1959. Details of the new cases are summarised in the following table:—

		AGE PERIODS												Total all Ages	
		0-	1-	2-	5-	10-	15-	20-	25-	35-	45-	55-	65-		75-
FORMAL NOTIFICATIONS:															
Respiratory, Males	...	-	2	8	6	5	20	16	35	49	57	75	49	12	334
Respiratory, Females	...	-	1	4	7	12	22	26	41	31	21	15	5	2	187
Non-Respiratory, Males	...	1	-	1	5	4	1	2	9	4	4	2	2	1	36
Non-respiratory, Females	...	-	-	2	4	4	4	7	6	3	4	-	1	-	35
															592
SUPPLEMENTAL NOTIFICATIONS:															
Respiratory, Males	...	-	-	-	-	-	1	-	-	-	3	8	3	6	21
Respiratory, Females	...	-	-	-	-	-	-	-	-	1	1	-	1	2	5
Non-respiratory, Males	...	-	-	1	-	-	-	-	-	-	-	-	2	-	3
Non-respiratory, Females		-	-	-	-	-	-	-	-	-	1	-	-	-	1
															30

The sources of information of the supplemental notifications were Local Registrars (12 respiratory and 1 non-respiratory), transferable deaths from the Registrar General (10 respiratory and 2 non-respiratory), and 5 posthumous notifications (4 respiratory and 1 non-respiratory).

OSTHUMOUS NOTIFICATIONS:

The following table gives the result of enquiries which have been made to determine the reason why there had been a failure to notify the 30 cases, the supplemental notifications, before the death of the patient.

Information obtained from Local Registrars' Death Returns:

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	78	Resp.	Pulmonary Tuberculosis.	Recluse. Doctor called in three days before death. Disease not realised until death. Health Visitor visited home address (isolated cottage). Only contact a housekeeper, who refused to attend for X-ray.
F.	81	Resp.	Senile pulmonary tuberculosis (bilateral).	Admitted to hospital as acute bronchitic, and died a few days after admission. Death certificate completed on evidence of X-ray.
M	52	Resp.	Hæmoptysis due to bilateral fibro-cavitational pulmonary tuberculosis. Certified by Coroner after P.M. without inquest.	Not known prior to P.M.
M	86	Resp.	1(a) Broncho-pneumonia. (c) Chronic fibroid phthisis.	General practitioner was contacted and enquiries made after this case was noticed on the Local Registrar's death returns. General practitioner stated that this case was never fully investigated and that he thought it was inactive.
M	70	Non-Resp.	1(a) Carcinoma of right kidney. 2 Tuberculous disease of right hip joint.	General practitioner was contacted and enquiries were made after this case was noticed on the Local Registrar's death returns. General practitioner stated that he always thought that this case was notified.
M	59	Resp.	Lobar pneumonia. Pneumoconiosis. Pulmonary tuberculosis.	Died in hospital. Diagnosis not established before death.
M	64	Resp.	1(a) Chronic congestive heart failure. (b) Pneumoconiosis and tuberculosis.	Patient was suffering from severe congestive heart failure. During last month of life, developed symptoms which, when seen by Consultant, were thought indicative of malignancy. Arrangements made for I.P. investigation, but patient died rather suddenly before possible to implement arrangements. The certified cause of death was given by the Coroner following post-mortem examination. The only household contact was patient's wife who was offered an appointment at the Chest Clinic. Other family contacts living nearby were also visited and offered appointments.

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	62	Resp.	1(a) Broncho-pneumonia. (b) Pulmonary tuberculosis. 2(a) Pneumoconiosis.	Not notified as tuberculosis as patient was a sufferer from industrial disease—pneumoconiosis. Tuberculosis discovered at P.M. All contacts listed and offered appointments to attend Chest Clinic.
M	80	Resp.	1(a) Coronary thrombosis. (b) Coronary atheroma. 2 Tuberculous lung. Chronic bronchitis.	Not diagnosed prior to death. Contacts followed up.
M	74	Resp.	Pulmonary tuberculosis and industrial disease of pneumoconiosis. P.M.	Diagnosis not made until after P.M. In receipt of pneumoconiosis pension from 1958. Refused to attend Chest Clinic when son notified in 1949. Grand-daughter, age 15, notified in 1951. Came out of mine 1941 due to chest trouble. Attended Pneumoconiosis Panel at Sheffield, 1958. All contacts attended Chest Clinic; all N.A.D.
M	64	Resp.	Pulmonary tuberculosis and the industrial disease of pneumoconiosis.	Found at Post-mortem for pneumoconiosis. Chest physician advised. Contacts examined.
F	44	Resp.	1 Chronic nephritis. 2 Tuberculosis of right upper lobe.	Not diagnosed until immediately prior to death. Chest physician advised. Contacts examined.
M	75	Resp.	Lobar pneumonia due to pneumoconiosis and pulmonary tuberculosis. Industrial disease.	Not diagnosed until after death. Referred to Chest Clinic for follow-up of contacts.

II. Information obtained from Registrar General's Transferable Deaths:

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	50	Resp.	Pulmonary tuberculosis.	Had apparently been notified in another area some 20 years ago. Considered to have been cured. This information was unknown in this area. Taken ill suddenly; sent to hospital where he died as a result of pulmonary tuberculosis. Health Visitor visited home. Daughter at school has been X-rayed. Own general practitioner to arrange wife's X-ray.
M	68	Resp.	1(a) Broncho-pneumonia. (b) Bilateral pulmonary tuberculosis. 2 Chronic pyelonephritis. Chronic urinary retention. Prostatitis & diabetes.	Belated diagnosis. Died in hospital. Contacts pursued routinely by Chest Clinic.

II. Continued

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	66	Resp.	1(a) Fibro caseous pulmonary tuberculosis. 2 Bone marrow aplasia.	Post-mortem revealed cause of death. Information obtained from hospital where patient was admitted for observation and died.
M	18	Resp.	1(a) Tuberculous meningitis. (b) Pulmonary tuberculosis. Coroner's P.M. without inquest.	Not known prior to post-mortem.
M	55	Resp.	Coronary thrombosis. Pulmonary tuberculosis (chronic). Acute pneumothorax.	Discovered at post-mortem. Patient's son was a registered notified case until 1959 when his name was removed as "recovered." Patient had been investigated as a contact at two-yearly intervals since 1947. Arrangements made for widow to be re-examined and for the son to be re-investigated.
M	82	Non-Resp.	Renal failure. Tuberculous kidney.	Died in hospital. Diagnosis not established before death.
M	67	Non-Resp.	1(a) Meningitis. (b) T.B. Spine. (c) Heart failure.	Patient died in hospital where he had been referred from Infirmary for treatment of tuberculous spine. The surgeon in charge of case was under the impression that the patient had been notified elsewhere as a case of tuberculosis. Enquiries by the Health Visitor revealed that patient was a retired miner. Said to have "always had good health" until about eight weeks before death. Patient lived alone with his wife aged 68 years. Wife suffers from a chronic cough and agreed to attend the Chest Clinic along with her married daughter living nearby.
F	45	Non-Resp.	1(a) Meningitis ? Tuberculous. (b) Broncho-pneumonia. (c) Tuberculous glands in abdomen. 2 Myasthenia gravis.	Patient in hospital under observation for ? tuberculous meningitis. Tuberculous glands proved on post-mortem. Husband, only contact, advised regarding examination.
F	87	Resp.	1(a) Broncho-pneumonia. (b) Cerebral arteriosclerosis. 2 Pulmonary tuberculosis.	Patient in hospital for pneumonia and died prior to test results being obtained as respiratory tuberculosis. List of contacts obtained and offered appointments to attend Chest Clinic.
F	49	Resp.	1(a) Lumbo sacral tuberculosis. 2 Tubercular pleural effusion.	Was being treated for malignancy at Centre for Radiotherapy. Tuberculosis was only found after death at the post-mortem. Tuberculosis Health Visitor visited and could not obtain any co-operation. This was reported to the chest physician.

II. Continued.

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	54	Resp.	Tuberculous pneumonia due to miliary tuberculosis. Myocardial fibrosis due to coronary occlusion and all aggravated due to shock of cut wrists.	Not diagnosed prior to terminal illness. Chest physician advised. Contacts examined.
M	57	Resp.	1 Terminal broncho-pneumonia due to pulmonary tuberculosis and pneumoconiosis. 2 Rheumatic mitral stenosis. Inq. P.M.	Died in hospital. Respiratory tuberculosis only discovered as a result of post-mortem examination. Action taken by Health Visitor to trace all contacts and refer them for examination at Chest Clinic.

III. Information obtained from Posthumous Notifications.

Patient			Cause of Death	Remarks
Sex	Age	Resp. or Non-Resp.		
M	79	Resp.	1(a) Pulmonary tuberculosis and ulceration of oesophagus. 2 Partial gastrectomy for duodenal ulcer.	Primary notification was received after this patient had died, therefore the chest physician was contacted and enquiries made as to why the case was not notified before death. Chest physician states that patient was admitted to hospital with a diagnosis of carcinoma of lungs and it was only discovered in the investigations just prior to death (by a positive sputum for T.B.) that patient was suffering from pulmonary tuberculosis.
M	58	Resp.	Pulmonary tuberculosis.	Not diagnosed until after death. All relatives and other contacts invited to Chest Clinic for X-ray.
F	74	Resp.	Tubercular laryngitis due to tuberculosis of lungs.	No illness whatsoever until loss of voice. Consulted general practitioner. Ill four months until death. Patient was a contact to her daughter who was notified a case in 1948 and died. Upon patient's death, all contacts referred to Chest Clinic for follow-up.
M	63	Resp.	Miliary tuberculosis and the industrial disease of pneumoconiosis.	Had been attending chest clinic since 1949. Discharged 1950 as non-T.B. 1956 returned to Chest Clinic and discharged again 1960. Domiciliary consultation—? bronchiectasis. Patient died and, on post-mortem, miliary tuberculosis discovered. All contacts visited and attending Chest Clinic.
M	2	Non-Resp.	1(a) Tubercular meningitis. (b) Tuberculosis of abdominal glands.	Admitted hospital December, 1959, vomiting. Under care of pædiatrician. Child gradually became worse and died. Post-mortem disclosed tubercular meningitis. All contacts followed up and X-rayed.

After adjustments for removals, recoveries and deaths, the total number of notified cases of tuberculosis on our register at the end of the year was 9,904, a decrease of 534 compared with the previous year. The following table summarises the revision of the registers in the respective divisional areas:—

Div. No.	Number of cases on register 1st January, 1960		Number of cases added to register		Number of cases removed from register		Number of cases remaining on register 31st December, 1960				Per 1,000 Popu- lation						
	Respiratory		Non- Respi- ratory		Respi- ratory		Non- Respi- ratory		Respiratory			Non- Respi- ratory					
	M	F	M	F	M	F	M	F	M	F		M	F				
1	220	170	41	44	20	7	5	6	36	35	12	204	142	33	38	417	5.2
3	236	141	46	33	12	6	3	3	10	8	1	238	139	46	35	458	8.3
4	249	157	20	34	23	19	—	4	73	48	16	199	128	10	22	359	5.3
5	360	212	52	56	35	24	2	4	37	16	3	358	220	50	57	685	6.1
7	43	42	6	7	3	6	3	—	3	9	—	43	39	9	7	98	4.1
8	184	146	26	40	25	8	3	4	15	12	2	194	142	28	42	406	5.2
9	83	54	14	11	12	11	—	2	17	6	2	78	59	13	11	161	3.2
10	145	121	19	26	6	4	1	1	9	9	2	142	116	20	25	303	6.6
11	225	157	20	20	21	9	2	2	25	18	3	221	148	15	19	403	6.7
12	247	170	40	55	24	14	2	2	27	22	6	244	162	39	51	496	8.3
13	169	105	14	29	16	9	—	3	27	16	4	158	98	11	28	295	3.5
15	72	72	31	22	12	2	2	—	23	15	4	61	59	31	18	169	3.5
16	103	98	18	19	11	16	2	2	13	14	2	101	100	19	19	239	4.2
17	71	52	9	19	2	4	2	2	13	14	9	60	42	8	12	122	2.5
18	221	142	20	9	21	17	1	—	28	20	5	214	139	19	4	376	6.5
19	171	134	29	30	28	23	3	—	28	21	1	171	136	31	29	367	6.8
20	228	171	38	53	23	19	3	4	42	38	11	209	152	27	46	434	4.8
22	397	284	108	83	29	25	1	2	81	65	31	345	244	76	54	719	8.0
23	242	186	26	39	33	23	3	1	26	27	1	249	182	27	39	497	7.4
25	231	169	37	29	21	10	2	1	23	20	1	229	159	37	29	454	5.9
26	113	92	18	20	12	5	—	—	9	11	—	116	86	18	20	240	5.1
27	164	139	35	19	23	8	—	1	29	15	1	158	132	35	19	344	8.4
28	201	167	45	37	32	24	3	1	26	15	1	207	176	47	37	467	7.3
29	153	130	34	33	13	10	3	—	18	18	—	148	122	35	33	338	9.7
30	303	192	28	41	16	11	1	1	33	20	3	286	183	28	39	536	8.4
31	266	171	47	38	28	16	2	—	20	19	6	274	168	47	32	521	5.6
Totals	5,097	3,674	821	846	501	330	49	46	691	531	127	4,907	3,473	759	765	9,904	6.0

Divisional Medical Officers have received 1,310 notifications (643 admissions and 667 discharges) relating to patients admitted to, or discharged from, treatment in 40 hospitals as follows:—

HOSPITAL	Respiratory								Non-Respiratory							
	Admitted				Discharged or Died				Admitted				Discharged or Died			
	Adults		Children		Adults		Children		Adults		Children		Adults		Children	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Bradley Wood Sanatorium, Huddersfield	15	4	—	—	17	4	—	—	2	—	—	—	2	—	—	—
Crookhill Hall Hospital, Conisbrough ...	31	—	—	—	43	—	—	—	1	—	—	—	—	—	—	—
Doncaster Infectious Diseases Hospital and Sanatorium Tickhill Rd., Donc'r	22	26	1	3	21	27	2	2	2	1	—	—	1	1	—	—
Gateforth Hospital, Hambleton, near Selby	94	21	—	—	83	16	—	—	2	1	—	—	2	—	—	—
Huddersfield Royal Infirmary ...	3	—	—	—	3	—	—	—	4	1	—	—	3	1	—	—
Killingbeck Hospital, Leeds ...	26	41	1	—	29	41	—	—	—	—	—	—	—	2	—	—
King Edward VII Hospital, Rivelin Valley Road, Sheffield ...	—	—	—	—	—	—	—	—	1	3	—	1	2	3	—	2
Lodge Moor Hospital, Sheffield ...	11	3	—	—	8	5	—	—	—	—	—	—	—	—	—	—
Northowram Isolation Hospital, Halifax	47	17	—	—	47	22	—	—	—	—	—	—	—	—	—	—
Oakwood Hall Hospital, Moorgate, Roth- erham ...	22	10	2	2	20	13	1	6	—	—	—	—	—	—	—	—
Scotton Banks Hospital, Knaresborough	26	7	—	2	25	4	1	1	2	2	1	—	2	1	1	1
Snapethorpe Hospital, Wakefield ...	3	3	—	—	3	5	—	—	—	—	—	—	—	—	—	—
Strinesdale Sanatorium, Oldham ...	2	3	—	—	2	3	—	—	—	—	—	—	—	—	—	—
The Hospital, Grassington, near Skipton	49	24	—	—	66	24	—	—	2	2	—	—	4	1	—	—
Wath Wood Isolation Hospital, Wath upon Dearne ...	25	11	—	1	30	9	—	—	3	1	—	—	1	1	1	—
Whitley Grange Hospital, Dewsbury ...	14	—	—	—	17	—	—	—	1	—	—	—	—	—	—	—
Winter Street Hospital, Sheffield ...	3	—	—	1	7	1	—	—	—	—	—	—	—	—	—	—
*Miscellaneous ...	15	6	3	5	16	4	2	3	4	—	1	—	2	—	—	—
	408	176	7	14	437	178	6	12	24	11	2	1	19	10	2	3

*The miscellaneous cases were under treatment at Ackton Hospital, Streethouse, near Pontefract; Bradford Royal Infirmary; Fairfield Hospital, York; Kendray Hospital, Barnsley; Marsden Hospital, Burnley; Moor-view Hospital, Meltham; Newstead Hospital, Fishpool, Mansfield; Pinderfields Hospital, Wakefield; Pontefract General Infirmary; Rawson Hospital, Rainworth, Mansfield; Royal National Hospital, Ventnor, Isle of Wight; St. Helen Hospital, Barnsley; St. James's Hospital, Leeds; St. Luke's Hospital, Bradford; Seacroft Hospital, Leeds; Sheffield City General Hospital; Sheffield Royal Infirmary; Staincliffe General Hospital, Dewsbury; The Hospital, Middleton-in-Wharfedale; Thornbury Children's Annexe Sheffield; Withnell Hospital, near Manchester; Wrightington Hospital, Wigan; York City Hospital.

Care and After-Care of the Tuberculous:

The ancillary services provided by the County Council are briefly summarised as follows:—

Extra nourishment, consisting of up to two pints of milk daily, continues to be available for domiciliary patients suffering from active tuberculosis; a total of 1,398 patients were granted free milk during the year and 742 persons were still on the registers on 31st December.

Domiciliary open-air shelters, beds, mattresses and bedding are provided to facilitate the segregation of the tuberculous patient who resides at home, but, due to better housing conditions, there is now little demand for the foremost.

Grants from the West Riding Distress Fund were made in 16 cases, 10 being for travelling expenses to enable relatives to visit patients undergoing hospital treatment, 2 for bedding, 1 for a nursery-type fireguard, 1 for cleaning materials and paint for an old-age pensioner who had been re-housed, 1 towards a holiday for a mentally sub-normal woman, and 1 towards the purchase of napkins, etc. for a new baby in a family where there were 6 other children and where the mother was not entitled to maternity benefit.

One patient whose condition did not permit of his return to normal competitive employment was admitted to the training settlement at Sherwood. There were 4 discharges, and, at the end of the year, there were 10 in residence—at Papworth (3) and at Sherwood (7).

CARE COMMITTEES:

Any review of Care and After-Care Services would be incomplete without reference to the work undertaken by Tuberculosis After-Care Committees. The work of a Care Committee is directed at easing the problems, both financial and otherwise, with which the tuberculous patient and his family have to contend. Because of their composition, the Committees are well-fitted for this task, for, in addition to laymen who are sympathetic towards the problems of the tuberculous, there are, serving with the Committees, persons who have specialised knowledge, e.g. Divisional Medical Officers, Chest Physicians, representatives of the National Assistance Board, etc., who are able to advise patients in need of help of the facilities available from statutory sources. This "expert" advice does tend to conserve the Committees' funds and ensures that help is given only to those patients and their families who are outside the scope of help provided by the statutory bodies. There are ten such Care Committees active in the West Riding area, three of which serve areas which include a county borough. The Care Committees provide services in sixteen divisional areas and cover approximately half of the County population. Their work is actively encouraged by the County Council who provide grants in aid to supplement the financial resources of the Committees; the grants for this year amounted to £1,040. These grants are distributed amongst the Committees according to the population served and the amount of expenditure upon benefits to patients. Many of the Committees have extended their activities to include the after-care of patients suffering from other chest diseases and heart conditions, and this extension of activity has resulted in an increased demand upon the resources of the Committees.

B.C.G. Vaccination:

An enquiry was made by the Ministry during the year to ascertain whether Medical Officers undertaking vaccination would be prepared to accept freeze-dried vaccine in the event of the Ministry ceasing to import fresh liquid vaccine from Denmark. The problem was discussed with the Divisional Medical Officers and, with one exception, they expressed themselves as being satisfied with the freeze-dried vaccine.

The opportunity was also taken during the year of discussing with the Divisional Medical Officers the value, or otherwise, of the twelve months post vaccination tuberculin test in view of the very small percentage of children who revert to mantoux negative. The Medical Officers, generally, were in favour of abandoning the test and it was left to individual discretion as to whether post vaccination testing continues to be undertaken.

There was a modification during the year to the Medical Research Council's Tuberculosis Vaccines Trial in which the Authority is participating. It is no longer possible to offer regular chest radiography to the volunteers in the scheme and the Medical Research Council have now asked to be informed at quarterly intervals of all notifications of tuberculosis occurring in persons born in the years 1935 to 1938. Continuation of the trial in this way should establish the duration of protection from B.C.G. Vaccination in adolescence. It will do much to determine national vaccination policy and to discover whether re-vaccination can be avoided.

Details of B.C.G. vaccination given to the various categories under Section 28 of the National Health Service Act are shown below:—

(a) CONTACTS.—A further 1,530 contacts were vaccinated, 8 of them being unsuccessful. Full details are shown in the following table:—

				AGE GROUPS											All Ages	
				Under 1 year Months				Years								
0–	1–	3–	6–	1–	2–	3–	4–	5–	10–	15–	20–					
Vaccinated:																
Male	89	89	84	52	40	43	45	29	130	114	33	30	778
Female	88	95	55	41	47	50	46	32	121	102	43	32	752
TOTAL	177	184	139	93	87	93	91	61	251	216	76	62	1,530
Result of Vaccination:																
Successful:																
Male	72	78	75	47	32	39	35	23	109	94	28	25	657
Female	76	79	50	37	44	44	41	31	109	85	41	27	664
TOTAL	148	157	125	84	76	83	76	54	218	179	69	52	1,321
Unsuccessful	1	—	1	—	—	—	—	1	1	2	1	1	8
Not finally ascertained	28	27	13	9	11	10	15	6	32	35	6	9	201

(b) SCHOOL CHILDREN.—Eleven thousand nine hundred and ninety-seven children were vaccinated under the County scheme, and the following is a summary of the work in the 24 divisions involved.

Acceptances:

Number of children offered tuberculin testing and vaccination if necessary	29,572
Number found to have been vaccinated previously	995
Number of acceptances	17,806
Percentage of acceptances	62.3

Pre-vaccination tuberculin test:

Number of children tested	...	...	...	...	...	...	16,577
Result of test:							
				<i>Heaf Test</i>	<i>Mantoux Test</i>		
Positive	...	...	...	2,454	1,032		
Negative	...	...	...	7,655	4,939		
Not ascertained	...	...	...	289	208	Total	16,577
Percentage positive	...	...	...	24.3	17.3	...	21.4

Vaccination:

Number vaccinated—

Following negative Heaf Test	...	...	7,154	
Following negative Mantoux Test	...	...	4,843	Total ... 11,997

Tuberculin test twelve months after vaccination:

Number tuberculin tested after 12 months	...	...	...	5,278
Result of test—				
Positive	...	...	...	4,703
Negative	...	...	...	462
Not ascertained	...	...	...	113
			Total ...	5,278

(c) STUDENTS ATTENDING UNIVERSITIES, TEACHER-TRAINING COLLEGES, TECHNICAL COLLEGES OR OTHER ESTABLISHMENTS FOR FURTHER EDUCATION.—Two hundred and ten students were tested, and, out of 107 negatives, 105 were vaccinated.

Mass Radiography:

Sixty-three thousand, five hundred and seventy persons from the Administrative County were examined by the Mass Radiography Service, 40,785 by units of the Leeds Regional Hospital Board and 22,785 by units of the Sheffield Regional Hospital Board. It will be seen from the tables below that 75 (0.12 per cent. of the total examined) cases of active tuberculosis, and 315 (0.50 per cent.) cases of inactive tuberculosis were discovered: there were also 1,051 (1.65 per cent.) non-tuberculous abnormalities found, 461 (43.86 per cent. of the total non-tuberculous abnormalities) of which were cases of pneumoconiosis. When separated into the two hospital regions, the percentage of cases of pneumoconiosis was 50.58 in the Sheffield Region, and only 31.23 in the Leeds Region.

A.—LEEDS UNITS

Survey undertaken in Division No.					Number Examined	Abnormalities Discovered				
						Tuberculosis		* Other	Total	
						Active	Inactive			
1	(Skipton)	...	..	..	...	4,014	1	17	37	55
4	(Shipley) ...	...	...	...	...	5,223	10	32	56	98
5	(Horsforth)	...	...	...	...	2,928	5	15	33	53
8	(Harrogate)	...	...	...	...	4,284	3	5	13	21
10	(Goole) ...	...	...	...	...	1,123	—	11	9	20
11	(Castleford)	...	...	...	...	4,041	—	4	46	50
12	(Pontefract)	...	...	...	...	161	—	—	—	—
13	(Morley)...	...	...	...	...	3,749	5	8	27	40
15	(Batley) ...	...	...	...	...	3,207	3	2	10	15
19	(Todmorden)	...	...	...	...	4,103	14	22	41	77
20	(Colne Valley)	...	...	...	...	3,873	6	23	19	48
23	(Hemsworth)	...	...	...	...	4,079	6	9	74	89
TOTALS					40,785	53	148	365	566	

B.—SHEFFIELD UNITS

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
22 (Wortley)	2,042	3	18	105	126
25 (Barnsley)	2,788	2	14	114	130
26 (Wath upon Dearne)	6,614	7	44	149	200
29 (Thorne)... ..	2,291	3	26	38	67
30 (Mexborough)	4,773	3	32	137	172
31 (Rotherham)	4,277	4	33	143	180
TOTALS	22,785	22	167	686	875

Totals for the County Area ... 63,570 75 315 1,051 1,441

*Details of the 1,051 “ Other ” abnormalities are as follows:—

	Leeds Region	Sheffield Region
1. Abnormalities of bony thorax and soft tissues—		
congenital ...	10	21
2. Abnormalities of bony thorax and soft tissues—		
acquired ...	5	9

3. Tumours of the bony thorax; primary and secondary	2	—
4. Congenital malformation of the lungs	2	—
5. Bacterial and virus infection of the lungs	26	17
6. Other infections of the lungs	3	2
7. Bronchiectasis	39	25
8. Honeycomb lung	—	—
9. Emphysema	6	17
10. Pulmonary fibrosis—non-tuberculous	31	84
11. Pneumoconiosis	114	347
12. Spontaneous pneumothorax	—	—
13. Benign tumours of the lungs and mediastinum ...	15	6
14. Carcinoma of the lung and mediastinum ...	11	7
15. Metastases in the lung and mediastinum ...	2	—
16. Enlarged mediastinal and bronchial glands— non-tuberculous	—	—
17. Sarcoidosis and collagenous diseases	5	1
18. Pleural thickening or calcification—non-tuberculous	23	36
19. Abnormalities of the diaphragm and œsophagus— congenital and acquired	6	20
20. Congenital abnormalities of heart and vessels ...	15	3
21. Acquired abnormalities of heart and vessels ...	46	87
22. Miscellaneous	3	4
23. Inquiries not completed	1	—
	<hr/> 365 <hr/>	<hr/> 686 <hr/>

VENEREAL DISEASES

Contributed by Dr. J. A. Burgess, Consultant Venereologist.

Before discussing the statistical data received from medical officers in charge of Special Treatment Centres concerning new cases of venereal diseases and other conditions in West Riding Administrative County residents the following notes are relevant.

It should be clearly understood that the figures given are not an accurate indication of the incidence of new infections. Venereal diseases are not notifiable in this country, hence the figures given are those only of patients who were registered at Special Treatment Centres.

It is well known that many patients (some authorities mention 20 to 25 per cent. of the total new cases) are treated by doctors other than at Special Treatment Centres. In addition, for every patient found to have infectious venereal disease, there is at least one individual who at the time of infection was not under treatment. For these reasons, the true incidence of venereal diseases in the Administrative County is probably in the region of two or three times the numbers given in this report. The figures do, however, give a fairly accurate indication, from year to year, of the trend of new infections.

New cases (compared with previous years).

TABLE A.

Year	Syphilis	Gonorrhœa	Total of new cases of Syphilis and Gonorrhœa	Other Conditions	Total of New Patients
1938	346	650	996	503	1,499
1939	403	678	1,081	593	1,674
1940	299	499	798	497	1,295
1941	331	552	883	587	1,470
1942	423	479	902	735	1,637
1943	487	654	1,141	1,344	2,485
1944	413	560	973	1,383	2,356
1945	473	767	1,240	1,419	2,659
1946	723	1,140	1,863	1,859	3,722
1947	573	729	1,302	1,511	2,813
1948	463	550	1,013	1,403	2,416
1949	435	383	818	1,360	2,178
1950	357	304	661	1,447	2,108
1951	247	171	418	1,212	1,630
1952	219	211	430	1,275	1,705
1953	214	182	396	1,228	1,624
1954	178	152	330	1,189	1,519
1955	175	135	310	1,168	1,478
1956	155	99	254	1,143	1,397
1957	152	125	277	1,078	1,355
1958	124	138	262	1,129	1,391
1959	112	405	517	1,352	1,869
1960	83	338	421	1,550	1,971

Syphilis in the above table includes early infectious, late acquired and congenital syphilis. Since 1946 the trend of new cases has been downwards and this was maintained in the year under review. On the other hand gonorrhœa fell in apparent incidence from 1946 to 1956 but during the next four years there was a considerable increase. In 1960 the total number of new cases from the Administrative County attending Special Treatment Centres with gonorrhœa fell to 338.

Other conditions include patients found to have (a) common diseases such as trichomoniasis, non-specific urethritis and cervicitis (inclusion blennorrhœa), and non-gonococcal urethritis, (b) several uncommon diseases such as lymphogranuloma venereum, granuloma inguinale, chancroid and yaws. The latter is not a venereal disease, but one of the treponematoses, prevalent in Africa and the West Indies. It is usually acquired by contagion in childhood. In recent years, the late non-infectious stage has been diagnosed more often in the West Riding because of the number of immigrants now resident here; (c) conditions not requiring treatment and undiagnosed conditions. This group is a fairly large one and includes uninfected contacts of known cases of venereal disease, also persons who had exposed themselves to the risk of infection but after undergoing examination and tests were found to be healthy.

It will be seen that, since pre-war days, the trend of other conditions was upwards until 1946, downwards to 1957 and then a resurgence to 1960. The present total being almost the same as that in 1947.

Table B.

Year	Early Acquired Syphilis	Congenital Syphilis under 1 year	Total Early Syphilis
1949	158	7	165
1950	76	4	80
1951	58	4	62
1952	19	1	20
1953	9	1	10
1954	7	—	7
1955	6	1	7
1956	9	—	9
1957	1	—	1
1958	5	—	5
1959	12	—	12
1960	—	—	—

This table shows the remarkable and gratifying fall in the apparent incidence of early (infectious) acquired syphilis and the less striking though no less important diminution in the number of patients with congenital syphilis under one year of age. For the fifth successive year there were no cases of congenital syphilis in infants. The statistics in this table were not available prior to 1949, but from that year onwards total early syphilis has, except for a slight rise in 1956, 1958 and 1959, fallen year by year to nil in 1960. If this trend continues there should be very few cases of late syphilis in the next decade.

New Cases (Quarterly and stage of disease).

Table C.

Quarter ended	Acquired Syphilis				Congenital Syphilis				Gonor-rhœa		Other Conditions	
	Early		Late		Under 1 year		Over 1 year		1959	1960	1959	1960
	1959	1960	1959	1960	1959	1960	1959	1960				
31st March ...	2	—	22	20	—	—	3	—	77	55	246	362
30th June ...	3	—	20	14	—	—	4	3	109	94	343	341
30th September	1	—	20	15	—	—	9	6	128	103	332	426
31st December	6	—	18	24	—	—	4	1	91	86	431	421
	12	—	80	73	—	—	20	10	405	338	1352	1550

In Table C the number of new cases of syphilis, gonorrhœa and other conditions diagnosed at Special Treatment Centres during each quarter of 1960 is given. The corresponding figures for the previous year are included for comparison. Late acquired syphilis fell in number by seven and late congenital by ten.

Gonorrhœa, although with us all the year round, is more prevalent during the summer months especially during the holiday months of July and August.

Other conditions increased in number by 198 compared with 1959.

New Cases (Treatment Centres).

Table D.

Special Treatment Centre				Syphilis	Gonor-rhœa	Other Con-ditions	Total
Barnsley Clinic, Queen's Road	...	...	...	1	18	92	111
Bradford St. Luke's Hospital	...	...	...	6	19	132	157
Burnley Victoria Hospital	...	...	...	—	—	5	5
Dewsbury General Hospital	...	...	...	11	26	92	129
Doncaster Royal Infirmary	...	...	...	12	88	234	334
Goole Bartholomew Hospital	...	...	...	2	3	10	15
Halifax Royal Infirmary	...	...	...	8	13	89	110
Harrogate General Hospital	...	...	...	4	13	88	105
Huddersfield Royal Infirmary	...	...	...	2	6	62	70
Keighley Victoria Hospital	...	...	...	2	21	74	97
Leeds General Infirmary	...	...	...	14	60	233	307
Oldham and District General Hospital	...	...	...	1	—	5	6
Rotherham Moorgate General Hospital	...	...	...	5	10	109	124
Sheffield Jessop Hospital	...	...	...	2	1	2	5
Sheffield Royal Hospital	...	...	...	—	1	20	21
Sheffield Royal Infirmary	...	...	...	1	2	15	18
Sheffield City General Hospital	...	...	...	—	—	—	—
Wakefield Clayton Hospital	...	...	...	8	47	265	320
York County Hospital	...	...	...	4	10	23	37
				83	338	1,550	1,971

The addresses of Special Treatment Centres at which new patients attended during 1960 and the number of cases of each disease diagnosed are given in Table D. These figures exclude patients who were transferred after diagnosis from one clinic to another, also patients who had defaulted from treatment in a previous year and returned during the year under review for treatment of the same disease.

New cases from the Administrative County attended at 19 different Special Treatment Centres during the year. Fourteen of these centres are in West Riding County Boroughs, two in Lancashire and three in West Riding Municipal Boroughs.

The largest number of new patients from the Administrative County attended at the Doncaster clinic. At this clinic also the greatest number of new cases of gonorrhœa was diagnosed.

On aggregate over the County the ratio of syphilis to gonorrhœa to other conditions was 1 : 4 : 19.

The overall percentages of new cases were, syphilis 4·2 per cent. (6·0 per cent.), gonorrhœa 17·2 per cent. (21·7 per cent.), other conditions 78·6 per cent. (72·3 per cent.). For comparison the figures given in parentheses are those for 1959.

V.D. Social Work:

The County Council is responsible for the direction and administration of measures taken to reduce the incidence of new venereal infections. There is little doubt that there is a considerable number of persons in the County who are infected with one or more of the venereal and genito-urinary diseases but who remain untreated. In many persons who acquire these diseases the symptoms and signs are so slight that medical advice is not sought. These people with asymptomatic genito-urinary infections can be classed as carriers. A few of them may from time to time have exacerbations with acute symptoms. If they are promiscuous they can infect many individuals before they are brought under examination and treatment. At the present time the most important task of the V.D. social workers is to find these carriers and persuade them to undergo medical examination by a specialist in venereology.

The staff consists of four Social Workers who are all state registered nurses with health visitor's certificates. The work comes under the immediate direction of a Consultant Venereologist who is adviser in venereal diseases to the County Council and is responsible to the County Medical Officer for V.D. prevention and after-care in the Administrative County. A confidential clerk-typist in the central office deals with the clerical and statistical work.

The County has been divided into four areas and each social worker traces the contacts, follows up the defaulters and is on the staff of one or more of the Special Treatment Centres in her area, in order to carry out the clinic social work. Three of the areas are coterminous with the County Boroughs of Dewsbury, Doncaster, Halifax and Wakefield and by arrangement three of the social workers undertake similar duties in these County Boroughs. This scheme operates smoothly and is a much better one for both patients and medical staff at Special Treatment Centres than having two social workers at each centre—one for County Borough patients and one for Administrative County patients.

Case finding is carried out by two main methods, (a) by giving patients found to be suffering from a venereal infection a contact slip which gives the reference number of the patient and the disease in code. The patient is asked to hand the contact slip to the person from whom he or she may have acquired the disease, with instructions that the contact should attend for examination at a Special Treatment Centre. The majority of contacts attending for examination do so as a result of receiving the contact slip. Actual numbers are not available but during the year the social workers had 1,704 miscellaneous interviews and 613 interviews with doctors. (b) If the first method cannot be used or is unsuccessful the social worker tries to obtain sufficient information regarding the contact so that he or she can be interviewed in private in order that the importance of medical examination can be explained. The number of County residents examined as a result of this latter method is comparatively small, detailed figures being given in Table E.

Table E.

Total number of contacts reported	...	69				
Located and examined	...		54			
Not infected	...			38		
Infected	...			16		
Already under treatment	...				—	
Brought under treatment	...				16	
Syphilis	...					4
Gonorrhœa	...					7
Other conditions	...					5
Located	...		8			
Not examined	...			6		
Transferred to other authority	...			2		
Not located	...		7			
Insufficient information	...			4		
Unable to locate	...			3		

Ante Natal Cases.

Pathologists working in the region send to the Consultant Venereologist the name and address of any doctor (but not the name of the patient) who has sent in for testing a specimen of blood from an ante natal patient giving positive tests for syphilis. The Venereologist through the V.D. social worker offers assistance to the doctor in arranging the examination and if necessary the treatment of the patient and her contacts. In some cases by this means whole families are examined.

Details of the ante natal cases and their contacts who were investigated by the V.D. social workers are given in Table F.

Table F.

Patients						Contacts		
Total number reported	No action taken	Number remaining	Found to have Syphilis	Found not to be infected	Transferred to other authorities	Number of contacts examined	Found to be infected	Found not to be infected
65	36*	29	12	7	10	23	5	18

* Already on register 16.
False positive 14.
Discussed by general practitioner with clinic medical officer 2.
Under care of own general practitioner 4.

It will be seen that at least 12 cases of potential congenital syphilis were prevented from occurring and that a total of 17 new cases with late syphilis were found.

The V.D. social workers as part of their duties in Special Treatment Centres follow up defaulting patients; that is, those who cease to attend before they are cured of venereal disease. This is done either by letters (enclosed in plain envelopes) to the patients or, if these are unsuccessful, by visits and private talks. No records are available of the number of letters sent. Table G gives details of the patients visited in the follow-up of defaulters from Special Treatment Centres.

defaulters.

Table G.

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Trans- ferred	Number of ineffective visits	Number of re-visits
267	163	49	14	41	410	348

PART IV

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Health Visiting

Home Nursing

Ambulance

Health Education

Recuperative Home Treatment

Provision of Nursing Equipment

Liaison

Chiropody

Domestic Help

Mental Health

CARE OF MOTHERS AND YOUNG CHILDREN

Vital Statistics:

								Admin- istrative County	England and Wales
Live Births									
Number	...	...	...	...	...	...	...	27,935	
Rate per 1,000 population	...	...	...	...	...	...	...	16.9	17.1
Illegitimate Live Births per cent. of total live births								4.0	
Still births									
Number	...	...	...	...	...	...	...	641	
Rate per 1,000 total live and still births	...	...	...	...	...	...	...	22.4	19.7
Total Live and Still Births								28,576	
Infant Deaths (deaths under 1 year)								628	
Infant Mortality Rates									
Total infant deaths per 1,000 total live births								22.5	21.7
Legitimate infant deaths per 1,000 legitimate live births								22.3	
Illegitimate infant deaths per 1,000 illegitimate live births								27.8	
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)									
								15.8	15.6
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)									
								13.7	
Perinatal Mortality Rate (still births and deaths under 1 week combined per 1,000 total live and still births)									
								35.9	
Maternal Mortality (including abortion)									
Number of deaths								21	
Rate per 1,000 total live and still births								0.73	0.39

Births:

A total of 27,935 live births was registered providing a crude birth rate of 16.9 per 1,000 population thus continuing the rise which commenced in 1956. In comparison, 27,044 births and a rate of 16.5 were recorded in 1959 and an annual average of 26,466, 16.3 in the quinquennium 1955-59. The number of births and the rate for 1960 were the highest recorded since 1949 and the increase of 0.4 per 1,000 population over the rate of 1959 suggests that the peak in the upward swing has not yet been reached.

The practice of relating births to total population, although convenient and conventional, may be misleading. Comparisons of crude rates of single districts or aggregates are not strictly valid since no regard is made to the varying sex-age composition of the respective populations. To surmount this difficulty an area comparability factor, which makes due allowance for the

proportion of women of child-bearing age in each local population, is applied to the crude live birth rates. The live birth rates for the past seven years adjusted by the factors applicable for the aggregates of Boroughs and Urban Districts, Rural Districts, the Administrative County, also the rates for England and Wales are given below:—

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1954	14·8	16·4	15·3	15·2
1955	14·9	16·8	15·4	15·0
1956	16·0	17·9	16·5	15·7
1957	16·2	17·9	16·7	16·1
1958	16·4	18·0	16·9	16·4
1959	16·2	17·6	16·7	16·5
1960	16·7	17·8	17·1	17·1

Illegitimate live births numbered 1,115 or 4·0 per cent. of the total live births. During the inter-war years the proportion of illegitimate births stabilised around 4 per cent. rising during the last war to a peak of 7·3 per cent. in 1945, thereafter declining to around 3·6 per cent. The proportion in 1960 is the highest recorded since 1950 but comprehensive statistics are not available to permit comment on the age groups primarily concerned.

The number of still births registered was 641 which corresponds to a rate of 22·4 per 1,000 total births. The rate is slightly higher than in 1959 when a low record was established, but compares favourably with an annual average of 23·2 for the quinquennium 1955-59. The ratio of illegitimate still births continues to be higher than the ratio of illegitimate births among live births. Still births registered as illegitimate constituted 5·1 per cent. of the total still births compared with 5·2 in 1959 and an annual average of 4·5 in the period 1955-59.

Infant Mortality:

Deaths of infants under 1 year of age numbered 628 giving an infant mortality rate of 22·5 per 1,000 live births. Both the number of deaths and the rate are the lowest ever to be recorded for the Administrative County. In comparison with the previous year the rate declined by 1·5 per 1,000 live births which, while encouraging, continues to be higher than the national rate of 21·7.

Apart from minor fluctuation in certain years, since the turn of the century there has been a progressive decline in the infant mortality rate as is indicated in the subjoined table:—

Period	Average Infant Mortality Rate		Year	Infant Mortality Rate	
	England and Wales	Administrative County		England and Wales	Administrative County
1901-1910	128	135	1956	24	27
1911-1920	100	109	1957	23	26
1921-1930	72	80	1958	23	24
1931-1940	59	61	1959	22	24
1941-1945	50	50	1960	22	22
1946-1950	36	40			
1951-1955	27	29			

The relative contribution to the improvement in the past five years by sex and age is indicated in the following table:—

	Number of Deaths					Deaths per 1,000 Live Births				
	1956	1957	1958	1959	1960	1956	1957	1958	1959	1960
<i>Male Infants—</i>										
Under 4 weeks ...	307	301	266	256	249	22.5	21.7	18.8	18.5	17.3
4 weeks—3 months ...	37	39	45	67	37	2.7	2.8	3.2	4.8	2.6
3—6 months ...	51	33	43	30	21	3.8	2.4	3.0	2.2	1.5
6—12 months ...	25	35	36	35	27	1.8	2.5	2.6	2.5	1.9
Total under 1 year ...	420	408	390	388	334	30.8	29.4	27.6	28.0	23.3
<i>Female Infants—</i>										
Under 4 weeks ...	214	208	195	183	193	16.7	16.0	14.8	13.9	14.2
4 weeks—3 months ...	28	37	35	32	42	2.2	2.8	2.6	2.4	3.1
3—6 months ...	25	33	30	22	39	1.9	2.5	2.3	1.7	2.9
6—12 months ...	31	25	17	24	20	2.4	1.9	1.3	1.8	1.5
Total under 1 year ...	298	303	277	261	294	23.2	23.2	21.0	19.8	21.6
<i>All Infants—</i>										
Under 4 weeks ...	521	509	461	439	442	19.7	18.9	16.9	16.2	15.8
4 weeks—3 months ...	65	76	80	99	79	2.4	2.8	2.9	3.7	2.8
3—6 months ...	76	66	73	52	60	2.9	2.5	2.7	1.9	2.1
6—12 months ...	56	60	53	59	47	2.1	2.2	1.9	2.2	1.7
Total under 1 year ...	718	711	667	649	628	27.1	26.4	24.4	24.0	22.5

The neonatal mortality rate is again slightly lower than in previous years, 15.8 per 1,000 live births as against 16.2 in 1959 and 16.9 in 1958, and is the lowest on record for the Administrative County. The subjoined table gives the number of deaths and the death rates per 1,000 live births at various ages in the neonatal period.

	Number of Deaths							Deaths per 1,000 Live Births						
	1954	1955	1956	1957	1958	1959	1960	1954	1955	1956	1957	1958	1959	1960
Under 1 day ...	184	185	235	237	216	211	227	7.6	7.5	8.9	8.8	7.9	7.8	8.1
1—7 days ...	193	180	210	200	175	157	157	8.0	7.3	7.9	7.4	6.4	5.8	5.6
1—4 weeks ...	64	63	76	72	70	71	58	2.7	2.6	2.9	2.7	2.6	2.6	2.1
Total under 4 weeks	441	428	521	509	461	439	442	18.3	17.4	19.7	18.9	16.9	16.2	15.8

More infants died in the first day of life than in the remainder of the neonatal period, while deaths under 1 week constituted 87 per cent. of the neonatal and 61 per cent. of the total infant mortality.

Associated with the redistribution of the ages at which deaths in infancy occur there is an alteration in the distribution of causes of infant death. The number of infant deaths assigned to the groups of diseases comprising the International Short List appears on page 28 but to gain a clearer appreciation a detailed analysis is given below:—

Ætiological Group	Cause of Death (and International Classification number)	Age at Death						
		Under 1 day	1 day and under 1 week	1 week and under 1 month	1 month and under 3 months	3 months and under 6 months	6 months and under 1 year	Total under 1 year
ALL CAUSES	All Causes	227	157	58	79	60	47	628
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (750-759)	29	39	18	19	19	8	132
	Total causes mainly of prenatal and congenital malformations	189	103	13	3	2	1	311
	Immaturity alone, or primary to diseases other than of early infancy (774, 776)	87	36	7	1	—	—	131
	Attributed to maternal toxæmia (769)	3	2	—	—	—	—	5
	Ill defined diseases of early infancy (773)	3	4	—	2	1	1	11
Postnatal Group	Postnatal asphyxia and atelectasis (762)	62	29	1	—	—	—	92
	Intracranial and spinal injury at birth (760)	26	26	2	—	1	—	55
	Other birth injury (761)	1	—	—	—	—	—	1
	Erythroblastosis (770)	5	2	1	—	—	—	8
	Hæmorrhagic disease of newborn (771)...	2	4	2	—	—	—	8
	Total causes mainly of postnatal origin	7	13	23	51	33	34	161
	Gastro-enteritis (including diarrhoea of newborn) (571, 764)	—	1	3	3	1	6	14
	Pneumonia and bronchitis (490-493, 763, 500-502)	2	10	16	33	27	21	109
	Other diseases of respiratory system (470-475, 510-527)	1	—	1	2	1	1	6
	Causes classified as infective (001-138): others mainly infective in origin (340, 391-393, 480-483, 765-768)	1	2	1	6	3	5	18
Unclassified	Whooping cough (056)	—	—	—	—	—	1	1
	Influenza (480-483)	—	—	—	—	—	—	1
	Otitis media and mastoiditis (391-393)	—	—	—	—	—	—	1
	Septicæmia, sepsis of newborn (053, 765-768)	—	—	—	—	—	—	1
	Meningococcal infections and non-meningococcal meningitis (057, 340)	1	1	1	3	—	2	8
	Causes classified as infective not mentioned above (remainder 001-138)	—	—	—	2	1	—	5
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E921-E925)	—	—	2	6	1	—	9
	Lack of care, neglect (including foundlings), infanticide (E926, E980-E985)	3	—	—	1	—	—	4
	Other violent causes (remainder E800-E999)	—	—	—	—	—	1	1
	Other remaining causes	2	2	4	6	6	4	24

The diagnosis of the cause of death of infants is frequently more difficult than at other ages and some of the individual causes must be used with caution. It is, however, illuminating that of the 628 infant deaths an autopsy was performed on 139; at ages under 1 day—32, 1-6 days—34, 7-27 days—12 and 1 month or over—61.

Of deaths during the first week of life 76 per cent. were due to conditions present before, or during birth, such as birth injury and immaturity but excluding congenital malformations. The latter accounted for a further 18 per cent. Within this period the causes of death, in descending order, were, immaturity (32 per cent. of the total deaths under 1 week), postnatal asphyxia and atelectasis (24 per cent.) and birth injuries (14 per cent.).

At ages one week up to one year the causes of death most frequently mentioned were pneumonia and bronchitis (40 per cent. of the total deaths at these ages) followed by infective diseases (6 per cent.) and gastro-enteritis (5 per cent.).

Perinatal Mortality:

In recent years the term perinatal mortality has been introduced to describe the combination of still births and deaths of infants under one week which gives an indication of the loss of infant life due to conditions associated with pregnancy and events during labour and delivery. The mortality rate is expressed per 1,000 total births and the following table gives the perinatal mortality rate also the death rate of infants aged one week and over for the past ten years.

	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960
Perinatal mortality (per 1,000 total births)	41.3	41.0	39.8	41.1	40.8	39.5	39.7	36.8	33.7	35.9
Infant deaths at 1 week and over (per 1,000 total births)	15.6	12.9	13.4	12.1	11.1	10.1	9.9	9.9	10.2	8.5

In the period 1954-59 the perinatal mortality rate progressively decreased to the record low level of 33.7; the rate for 1960, although an increase of 2.2, is the second lowest recorded. Under the Population (Statistics) Act, 1960, on or after 1st October, 1960, doctors and midwives are required to record the cause of death of each still birth they attend, also the estimated duration of the mother's pregnancy and the weight of the foetus, if known. The object is to provide a regular series of statistics on the cause of still birth which, together with other information obtained at registration of the birth, should assist materially in future studies on perinatal mortality. The cause of death of a still birth may be little different from that of a baby who lived a few minutes or a few days after birth. The new Act should permit much more information to be compiled on this and allied subjects.

So far as statistics relating to deaths of infants under one week are concerned, prematurity was the principal cause with 63 per cent. of them having a birth-weight 5½ lb. or less. A high proportion of the infants lived but a few hours and, although conforming to the definition of live birth, the period of gestation of 20 deaths was recorded as being under 28 weeks. Injuries and asphyxia sustained during birth took a heavy toll followed by congenital malformations which were so severe as to make continued separate existence impossible.

At ages one week and under one year the rate declined to 8·5 per 1,000 total births, the lowest yet recorded. Slight fluctuations are to be expected now that the mortality at these ages is so low and further permanent reductions, although possible, will be difficult to achieve.

Maternal Mortality:

There were 21 deaths classified to maternal causes—sepsis 7, toxæmia 3, other complications 6, abortion 5. Of the abortions, 4 were criminal involving two convictions for manslaughter.

The maternal mortality rate was 0·73 and the following table gives comparable figures for the four previous years.

Cause of Death	1956		1957		1958		1959		1960	
	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales
Maternal sepsis (not associated with abortion) ...	0·04	0·06	0·07	0·07	0·04	0·07	0·04	0·06	0·24	0·31
Toxæmias of pregnancy and puerperium (not associated with abortion) ...	0·11	0·13	0·07	0·10	0·14	0·09	0·14	0·07	0·10	
Other complications of pregnancy, childbirth and the puerperium ...	0·30	0·23	0·29	0·20	0·18	0·19	0·18	0·18	0·21	
Abortion (with or without mention of sepsis or toxæmia) ...	0·07	0·10	0·07	0·08	0·07	0·08	—	0·06	0·17	0·08
Total Maternal Mortality...	0·52	0·52	0·51	0·45	0·43	0·43	0·36	0·38	0·73	0·39

Ante and Post natal Services:

In the light of the increasing numbers of expectant mothers obtaining maternity medical services from their own medical practitioners, it would be natural to assume that local authority clinic attendances would be reduced proportionately; however, statistics are to the contrary. There is a changing pattern in the type of service being sought at ante natal clinics—namely, the educational as against the clinical—which accounts for the increased attendances (2,000) at midwives' sessions. These sessions afford the opportunity, at probably the most receptive time in the life of the expectant mother, of educating and advising in the care and management of herself and her baby.

There were 157 ante and post natal clinics in operation at the end of the year, and the number of women who attended, prior to confinement, was 11,498, of which 9,078 were new cases. Post natal attendances continue to decline; 1,169 women attended as against 1,301 the previous year.

Ante Natal Teaching:

Since 1948, when the first organised talks were given to West Riding midwives on the ante natal preparation of the expectant mother, the concept of the work has altered radically.

The late Mrs. Helen Heardman gave several talks and demonstrations in 1948, when the whole emphasis was on the work of the physiotherapist and the training in physical exercises and relaxation of the mother.

In 1950, a number of midwives, who attended the Leeds School of Physiotherapy one afternoon a week for twelve weeks, later initiated the first ante natal classes in the County.

The first residential course at Grantley Hall was held in 1952, and repeated with slight alterations in 1953. These sessions were used by Miss M. Ebner, Physiotherapist, Leeds United Hospitals, and her two colleagues with the emphasis on the exercises and relaxation, with explanations of the labour processes.

The midwives were enthusiastic about the physical exercises and taught relaxation, but it was felt that more appreciation of the psychological approach and more explanations were needed, and the 1954 course included a talk by Dr. Herbert, a general practitioner obstetrician with a family of her own.

At this time, invitations were sent to local county boroughs and midwives from Halifax and York attended the course.

In 1955, a week-end refresher course was given to the midwives who had attended the Leeds external training, and Dr. Bruce of Storthes Hall spoke on "Sanity of Pregnancy," which made some impression on those present, but difficulty was still found in some clinics in giving short talks and discussions.

The result was that, for the 1958 course, Miss Ebner alone was invited for half the time, with lecturers from the Central Council for Health Education and Dr. Valentine, Consultant Psychiatrist, Scalebor Park Hospital, as the visiting speaker on mental health. A special feature was the holding of a forum with a delivered mother and the rest of the teaching team. This course was lively but little use was later made of the instructions on poster painting and preparation of flannelgraphs, so the experiment was not too successful.

The following year, Miss Ebner was there for the full course, with Miss Burns, a York physiotherapist, present for half the time. Talks were also given by Dr. Burbury, Psychiatrist, and Miss Cairney, a dietitian from the Ministry of Health. Miss Cairney's talk was not only instructive but her control of audience participation was an outstanding feature. Miss Powlett, a free lance lecturer on methods of teaching, attended throughout, giving useful instruction in the art of leading discussion groups and in the use of simple visual aids to stimulate talking.

This course was felt to be a great improvement by the midwives from the County Council's area and from Bradford, Barnsley, Doncaster, Hull and York.

About this time, there was correspondence in professional papers about the psychological difficulties of the mothers who were writing to the women's papers about matters which should have been explained to them by their midwives. To try to understand this, we asked Anne Cuthbert of "Housewife" to speak to the midwives in an effort to explain these facts. Miss Cairney and Miss Powlett again contributed, but, as Miss Ebner had retired, Miss Burns became the physiotherapist with Mrs. Barlow there to help for part of the time.

The three physiotherapists have been associated with this work since its inception and have borne patiently, and, indeed, have been very interested in, the experiments in this training course.

This is the history of the beginnings of relaxation and approach to motherhood. Now, let us do an evaluation of how members of the team have reacted to these classes and their advantages and disadvantages.

The attitude of general practitioners is variable; in one or two areas, they hold classes and, in others, they encourage mothers to attend those run by the local health authority. Others think they have no value but do not *mind* the mothers attending.

The attitude of the midwives.

The majority think the classes are worth while, but some are a little unsure of their own capabilities and need experience and guidance. Some classes have been maintained for years, but others have ceased for various reasons—shift work of husbands, shortage of midwives—and, in some areas, no classes have been started.

The attitude of the mothers.

While admitting that some girls have an easy labour without any preparation such as this, and some, who have had it, may have some difficulty in labour, there is evidence to show that the girls who do attend *believe* the classes have been beneficial. Such evidence has been obtained from letters sent by mothers describing the easy labour, by tape recordings of the stories told by delivered mothers, and by the enthusiasm expressed by them after delivery when visited at home. Matrons of various general practitioner homes have said, with a varying amount of enthusiasm, that the patients are more controlled in labour and some go as far as saying, “I can always tell when a girl has been to classes.”

The Supervisors of Midwives have personally talked with many mothers and, when they have asked which part of the classes they most enjoyed or found useful in labour, the replies were:—

- (i) The breathing—it was so easy.
- (ii) Knowing “all about it”—knowing what to expect.
- (iii) Having previous knowledge of the use of analgesic machine.
- (iv) A few say the exercises.

Almost any midwife will admit that, to-day, labour is not only easier but shorter than formerly, and the records in the case books do support this belief. However, whether it is the effect of the classes or the use of pethidine is doubtful in the minds of some midwives. There is no doubt that many girls have real belief in the value of the classes and this surely would justify the continuation, or establishing, of such classes. Often the exercises do not come quite up to “physiotherapy” standard, but the mothers rather like them and many midwives express the view that the exercise programme gets them there and also conditions them for the discussions, so—in all—it is better this way.

Advantages of classes.

- (i) Creates a more relaxed relationship between the expectant mother and her midwife, so reducing fear of personality problems.
- (ii) Mothers meet together and voice their problems and fears. They are shared experiences and each gains confidence from discussion and contact with others.
- (iii) Experience by mothers in the use of analgesic apparatus and learning about labour aids such as pethidine; this gives them confidence.

- (iv) The exercises are most useful in toning up the muscles during the ante natal period and in the preparation for labour by teaching correct breathing and posture, and this is carried forward into the post natal period.
- (v) Economy in time as the midwife can, and does, meet a number of people at once and so reduces the amount of home visiting. This does not apply to girls booked for hospital delivery.
- (vi) The hospital-booked patient seems to have an additional disadvantage over the domiciliary one, as the latter does see her midwife on a fairly relaxed basis in her own home, but the former rarely gets beyond the impersonal care given in a busy ante natal clinic.
- (vii) The health visitor meets the people she will be visiting at home and seeing at the infant welfare clinic later, and so is given an easier access.

Disadvantages of classes.

There should not be many, but midwives who are not enthusiastic say:—

- (i) They have no time.
- (ii) They cannot guarantee continuity. This need not apply if the health visitor is part of the team supplying this service, and it would seem that this is not a good reason for not trying.

General outline of programme.

This varies enormously according to circumstances.

- (i) *Physical* relaxation provided by exercises which tone up the muscles and put them to correct use during labour, i.e. breathing exercises, position at different stages, etc.
- (ii) *Mental* relaxation by attempting to eliminate any doubt, ignorance or fear. The simple telling of the changes taking place in pregnancy and labour, use of analgesics and discussions on “old wives’ tales.”
- (iii) *Health teaching.* Diet and nutrition, with particular reference to baby’s requirements, etc. Clothing, infant clothes, preparation, etc.
- (iv) *Welfare State social benefits.* Insurance, food complements. Services to be found at the health centres.

The pattern in this aspect of midwifery varies enormously; in some areas, the physiotherapist or health visitor takes full responsibility. In others, the midwife works alone. In some, it is the combined efforts of the health visitor and the midwife and it is these classes where the mother derives the most benefit and where she realises there is a continuance of the service afterwards.

Dental Treatment of Expectant and Nursing Mothers and Pre-School Children:

The Chief Dental Officer states:—

Once again it is necessary to report that, owing to the shortage of dental officers, there has been very little change in the volume of treatment carried out for expectant and nursing mothers.

The following table indicates the work which has been carried out during the year by our own dental officers and private practitioners under the County Scheme.

Number of cases referred	3,671
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				By County Dentists	By Private Practitioners	Total
Number of cases examined	1,300	1,634	2,934
Number of cases found to require treatment				1,285	1,573	2,858
Number treated	...	...	...	1,175	1,494	2,669
Number made dentally fit	...	...	...	985	1,402	2,387
Number of extractions	...	...	...	8,238	11,975	20,213
Number of fillings	...	...	...	1,738	2,033	3,771
Number of general anæsthetics	...	...	...	858	803	1,661
Number of scalings	...	...	...	596	521	1,117
Number of complete dentures	...	...	...	1,148	1,594	2,742
Number of partial dentures	...	...	...	409	580	989
Number of X-rays	...	...	...	86	61	147
Number of crowns/inlays	...	...	...	11	24	35
Number of root treatments	...	...	...	9	3	12
Silver Nitrate	...	...	...	0	2	2

The following work has been carried out during the year for pre-school children by school dental officers:—

Number inspected	...	...	...	...	1,326
Number treated	...	...	...	...	1,092
Number of attendances	...	...	...	...	1,449
Number of extractions	...	...	...	...	1,903
Number of general anæsthetics	...	...	...	...	817
Number of teeth filled	...	...	...	...	344
Number of fillings	...	...	...	...	368
Number of teeth treated with silver nitrate	...	...	...	...	206
Number of dressings	...	...	...	...	28
Number of scalings	...	...	...	...	0

Infant Welfare:

At the end of the year, there were 228 static and 2 mobile child welfare centres in operation, at which 474,193 attendances were made—an increase of 6,913 over the previous year. An analysis of the total attendances shows that 91 per cent. of the age group “under one year,” 63 per cent. of the age group “one year but under two years,” and 17 per cent. of the age group “two years but under five years” attended centres during the year.

The erection of six additional general-purpose clinics was completed during the year at Grimethorpe, Airedale, Wombwell, Parson Cross, Horsforth and Dunscroft; the Wombwell, Parson Cross and Horsforth clinics include dental facilities. The total number of new clinics erected in the post-war years is now 13. The present capital building programme provides for the erection of a further 35 clinics and, of these, it is anticipated that 21 will be erected, or partly erected, by the end of the financial year 1961/62.

In addition to the building of new clinics, the County Council have, in the post-war years, adapted as general-purpose clinics 25 properties which were already in their possession or have been bought or leased with the object of providing clinic accommodation. The overall picture, therefore, is that, when the present building programme is complete, the County Council will have some 106 general-purpose clinics—the provision of which must be regarded as a noteworthy achievement.

A large proportion of the total of 228 clinics is in respect of infant welfare centres held in rented premises, such as church and chapel halls, at weekly or less frequent intervals. While everything possible has been done to improve the facilities available at these clinics, many of them can never be regarded as satisfactory, but the need for clinic services generally is such that their replacement by new special purpose-built clinics could not be justified.

As part of their arrangements for infant welfare, the County Council continue to have available to them the services of Dr. Harvey, the County Pædiatrician, who reports as follows:—

“ Infant Welfare.

The Newborn Baby. The past year has seen a rapid widening of the horizon of genetic causes for malformations and metabolic disorders which may make babies fail to thrive. There will clearly be need for deployment of highly specialised effort in chromosome studies of selected odd-looking babies. Such laboratory work is, however, so refined and exacting that it will at first only be possible to seek answers to those problems with exceptional scientific interest, or in which eugenic guidance depends on the result. What help, for instance, can be given to a woman who has three anencephalic premature babies in a row after one normal child?

Infant Mortality. One of the most valuable steps in seeking to lower infant mortality still further will be to make every possible study of the cause of still births and infant deaths by post-mortem examination. Our pathologist colleagues are happy to do their share in this work, and the problem is to secure the encouragement of family doctors in getting consent from parents, especially in still births or deaths at home. In many cases the post-mortem findings are so unexpected and enlightening that they afford comfort to parents, and reassurance for the future which they could otherwise never have had. For instance, a baby with severe blueness and defective expansion of the chest in the newborn period could have left parents and midwife wondering whether there was some avoidable cause in the handling of the confinement. The post-mortem examination showed absence of the left half of the diaphragm with stomach and intestine crowded up into the chest, displacing the heart and compressing the lungs in a way which was incompatible with survival. It was not a matter for any possible blame and, genetically, the condition is unlikely to recur in future offspring.

Detailed routine examination of the newborn baby is sometimes overlooked if the mother's condition calls for special attention. It is, however, important that a note be made that the baby's bowels and bladder empty normally in the first 12 hours of life, because urgent examination for malformation would be needed otherwise, and malformations do not always occur singly. One recent baby was born with an imperforate anus which needed prompt surgical relief, but at the same time his attacks of blueness and indrawn chest wall led to the discovery that his œsophagus ended blindly in the chest and needed a formidable reconstructive operation.

Rhesus incompatibility of mother's and baby's blood is associated with some misunderstandings and an occasional dangerous oversight. With one baby there was a chapter of accidents, in which both the ante natal clinic blood sample and the confinement blood samples were mislaid, and the baby's hæmolytic disease was only discovered as he

developed extreme pallor when two weeks old. This needed two transfusions. The oversight had denied him the possibility of exchange transfusions at birth, which might have been preferable. The outcome was satisfactory. Many mothers attribute all the supposed ailments of their children to the fact that they have been told they themselves are Rhesus negative. It is important for doctors and nurses to be able to set their minds clearly at rest that, in the great majority of cases, if there have been no antibodies found at the routine tests, then no problem of incompatibility or risk to the baby arises. The second thing about which mothers need reassurance when the baby has been sensitised is that the hæmolytic disease process is a self-limited one. After the first two months of life, when the blood has returned to normal, there is nothing more to fear for the future for the child, assuming that bile pickling of the brain has not been allowed to occur.

I still have yet to see my first case of neonatal cold injury. Is this a disease of the fashionable south, which does not happen in our well-heated, Yorkshire coalfield residences?

B.C.G. Vaccination of newborn babies has been the subject of recent discussion, based on acceptance of the policy of the Ministry of Health and the Boyd Committee on immunisation that general B.C.G. vaccination of the newborn should not be offered but that it should be reserved for babies exposed to tubercle contact hazard. Alongside this consideration, it is impressive to see how a positive skin tuberculin test in a school entrant leads time after time to the discovery of an unsuspected adult source of tuberculous infection.

Feeding Problems. I am seeing far fewer feeding problems of babies at my clinics than ten years ago. Is this because mothers are making better use of good advice at the infant welfare clinics or because the use of half-skimmed milk has been virtually abolished? Two recent cases, nevertheless come to mind: one baby, who was sent up simulating pyloric stenosis, had been put on half-skimmed milk, $2\frac{1}{2}$ scoops to 5 ounces of water, and had naturally become ill with starvation. The other was a premature baby who lingered in extreme emaciation to three months old and died of pneumonia with severe liver degeneration. A possible contributory factor was a period of protein starvation when the child had been kept on glucose water as a treatment for diarrhoea. It is still too commonly thought by doctors that "clear fluids" form the appropriate treatment for diarrhoea for days on end. Some young babies' livers cannot stand deprivation of milk protein for longer than a few hours.

Insomnia. Nowadays there seem to be fewer babies and toddlers causing a domestic crisis with insomnia. After life's fitful fever they sleep well, most of them; but, when they don't, father and mother come together in solemn desperation to be sorted out. Usually it is the self-limited phase of a few months in which the infant has derived such complete benefit from four hours of innocent sleep that he is ready by midnight for half a night's play. Many doctors prescribe phenobarbitone as a hypnotic or sedative for young children but, in this age group, its only value is for epilepsy; it fails to bring sleep to the lively or repose to the fidgety.

An occasional new locum doctor still sends babies up for the obsolete operation of circumcision, or under pressure of the grandparents perhaps for cutting of a so-called tongue-tie. One mother spent months rubbing her child's gums with her finger to stretch the attachment of the tongue, apparently because she knew she herself had undergone ritual tongue-cutting when two months old.

I am intrigued by mothers who fairly commonly bring a neighbour to act as their spokeswoman at the clinic. Is it through timidity or educational subnormality? The same mothers usually show the physical sign that they cannot dress the baby on the clinic couch. They rub their forehead in dismay, sit down with the baby and then go through the movements of dressing across their knee.

Toddlers.

The Very Young Deaf Child. It is gratifying that expert diagnostic clinics are being set up this coming year for making sure about the urgent problems of serious hearing loss in infancy. Such questions are commonly brought into focus by puzzling discrepancies between various aspects of performance in a baby or toddler. For instance, motor and manipulative abilities are normal, but the child lacks the associated normal progress from babbling and jargon to speech. My plea is that such discrepancies be brought forward

urgently for pædiatric developmental study, yet without delaying specific audiological study. Pædiatric study along Gesell's well-proved lines will broaden the basis of subsequent (or parallel) hearing assessment. Redeployment of our effort in such ways is becoming possible now that infective and feeding problems absorb less time.

The heartbreak of severe mental subnormality. Many instances again this year have arisen of parents in desperate emotional straits with the exhaustion of handling restless aments, to the serious disadvantage of normal children in the family, or—even more pathetically—parents are unable to contemplate adding to their family after a subnormal firstborn. We have admitted several such children repeatedly to acute general hospital wards, as a compassionate exception to the rule, to give parents temporary respite. But our acute wards are not intended and they are not staffed for work like this. Clearly, a considerable increase in admissions to long-stay institutions for severely subnormal children is needed, and also much more long-stay accommodation for severe physical handicaps, such as the increased numbers of hydrocephalic and cerebral palsy children now surviving.

Accidents in early childhood. Poisonings continue to be a distressing as well as shameful feature of infant life. We had one fatality at 19 months in a child who had eaten an older child's bed-wetting tablets. The commonest tablets of all, iron and aspirin, are both deadly to small children. Amongst the other misadventures which children reach out for are pea-nuts, which they may inhale into their lungs to cause collapse and septic pneumonia. I have had three such children in a little over a year who became desperately ill before the parents thought to inform us that the child had choked suddenly a week or two earlier, after climbing up to get some pea-nuts from a shelf, for instance. Removal of the nut by bronchoscopy can be a grave surgical procedure in the presence of extreme bronchial spasm and infection. Another toddler foxed us in a different way with an offensive bloodstained nose discharge after an attack of mouth ulcers. It turned out that the two were unconnected. What she had reached out to grasp was a fragment of a rubber sponge which she had stuffed up her nostril.

Convulsions. The seriousness of epilepsy is well enough realised, and the possible gravity of feverish convulsions as the beginning of meningitis or other illnesses. As a relief from such thoughts, it is still often a pleasure to find that children referred for convulsions are merely displaying the innocent breath-holding mechanism which has no serious significance. One such child, at the tender age of two months, began 'convulsing' in this way with the recurring displeasure of having her face washed. Another gratifying revision of the diagnosis of supposed epilepsy was in a five year old boy: his two 'attacks' were his first bout of car-sickness on a family trip to Chatsworth.

Tapeworms. Twice this year I have been deceived in a similar way through relying on mothers' descriptions that their toddlers were revoltingly afflicted with threadworms. Being inclined myself to regard threadworms as scarcely more serious than freckles, I had cast around for other clues, such as maternal maladjustment. At subsequent visits, it transpired that the so-called threadworms were, in fact, detached motile single segments of tapeworm. Both worms yielded to vigorous in-patient drug treatment."

Phenylketonuria:

Phenylketonuria is an inherited metabolic disease wherein protein breakdown is blocked and the poisonous by-product, phenylpyruvic acid, accumulates in the blood causing brain damage and mental deterioration. Early diagnosis permits of special dietary control, thus preventing irreversible mental deterioration. The incidence of this condition in the country is estimated at 1 per 50,000 of the population.

A simple test, capable of being undertaken by a health visitor between the second and sixth week of the life of the infant, can indicate whether or not phenylpyruvic acid is present in the urine; however, laboratory confirmation that a suspected case is positive is required in all cases.

During the early part of the year, the Hospital Boards of Leeds and Sheffield indicated the pathological laboratories to which samples from positive screen testing could be sent for confirmatory examination, and the screening, aimed at 100 per cent. of newly-born infants, was commenced on the 1st March.

At the end of the year, 21,034 infants had been tested, whilst the parents of 11 infants refused permission for the test to be undertaken. Five positive reactions were obtained but, of these, only two were confirmed to be phenylketonurics following laboratory examination.

The first case, a male infant born on 9th October, was admitted to hospital on the 8th December, 1960, when it weighed 10 lb. 10 ozs. Delay in screening, carried out on the 5th December, 1960, was due to the fact that the mother, a business woman, was only at home one day per week and there was not any access to the infant. Dietary stabilisation was effected, and the infant was discharged from hospital on the 1st March, 1961, at a weight of 14 lb. 3 ozs. The hospital report indicated that the last serum phenylalanine was less than 2 m.g. per cent. and that mental and physical development was normal.

The second confirmed case, a female infant born on the 15th December, 1960, weighing 4 lb. 8 ozs., was under hospital investigation for a period of three weeks without any dietary treatment being undertaken. Although four very strongly positive urine tests indicating phenylketonuric reactions were obtained, the blood test was always negative. On the 12th May, 1961, she weighed 14½ lb.; her physical and mental reactions were normal. It is doubtful whether this case is one of phenylketonuria.

Welfare Foods:

The arrangements for the distribution of welfare foods from Child Welfare Centres, Divisional Health Offices and, to a lesser extent, from private householders and the retail trade, have continued during the year. The following table indicates the extent of distribution of the welfare foods for 1960 and comparative figures for the year 1959.

Period	National Dried Milk (Tins)		Cod Liver Oil (Bottles)		Vitamin A & D Tablets (Packets)		Orange Juice (Bottles)	
	1959	1960	1959	1960	1959	1960	1959	1960
January-March	53,819	48,167	26,990	25,262	16,552	17,679	150,538	148,374
April-June ...	52,547	45,412	21,849	20,685	16,508	16,977	184,050	175,070
July-September	52,499	43,891	20,658	20,335	17,090	16,693	196,341	164,050
October-December	51,385	44,468	25,142	27,151	16,337	17,697	144,375	149,656
	210,250	181,938	94,639	93,433	66,487	69,046	675,304	637,150

At 31st December, there were 322 distribution centres in the County for the issue of welfare foods, of which 214 were child welfare centres.

Illegitimate Children:

Of the total of 1,115 live illegitimate births, 828 were dealt with as indicated in the table below; 782 of them were of West Riding domicile, the remaining 46 being non-County cases. Of the County cases, 190 were accommodated during the ante or post natal period in moral welfare homes under the scheme of the authority.

				West Riding Cases	Non- County Cases	Total
Number of cases dealt with during the year:						
Referred by Moral Welfare Organisations	...			154	26	180
Ascertained by Staff of the Health Department				527	5	532
Referred by other services	...	...	...	101	15	116
				—	—	—
Totals	...	...	...	782	46	828
				—	—	—
Analysis of cases:						
Married	{	with previous illegitimate children		93	1	94
	{	without previous illegitimate children		131	4	135
Unmarried	{	with previous illegitimate children	...	119	—	119
	{	without previous illegitimate children		412	40	452
Widowed	{	with previous illegitimate children	...	12	—	12
	{	without previous illegitimate children		15	1	16
				—	—	—
Totals	...	...	...	782	46	828
				—	—	—
Ages:						
Under 16 years of age	...	...	...	19	—	19
16—19 years of age	...	...	...	175	19	194
20—25 years of age	...	...	...	276	21	297
26—30 years of age	...	...	...	134	3	137
31—40 years of age	...	...	...	161	3	164
Over 40 years of age	...	...	...	17	—	17
				—	—	—
Totals	...	...	...	782	46	828
				—	—	—
Disposal:						
Cases settled—Marriage	...	...	...	31	2	33
Baby died	...	...	...	30	1	31
Grandparents taking baby	...			52	1	53
Baby adopted	...	...	...	130	25	155
Baby fostered	...	...	...	15	5	20
Mother keeping baby	...	...	...	504	5	509
Cases referred elsewhere	...	...	...	9	7	16
Cases not finally settled	...	...	...	11	—	11
				—	—	—
Totals	...	...	...	782	46	828
				—	—	—

Accommodation was provided for the 190 cases in moral welfare homes as outlined below:—

	Ante and Post natal	Ante natal only	Post natal only	Governing Body
Blackburn—The Grange, Wilpshire ...	2	—	—	Church of England
Bradford—Oakwell House ...	10	—	—	Bradford Corporation
Bradford—St. Monica's Home ...	16	3	—	Church of England
Darlington—St. Agnes' Home ...	1	—	—	Church of England
Devizes—Mother and Baby Home ...	1	—	—	Voluntary Committee
Halifax—St. Margaret's Home ...	23	2	3	Church of England
Harrogate—St. Monica's Home ...	16	—	—	Church of England
Huddersfield—Queen Street Mission ...	2	—	—	Methodist Church
Huddersfield—St. Katharine's Hostel ...	3	—	—	Church of England
Leeds—Browning House ...	17	1	2	Voluntary Committee
Leeds—Mount Cross, Bramley... ..	7	—	—	Salvation Army
Leeds—St. Margaret's Home ...	18	1	—	Roman Catholic Church
Lincoln—The Quarry Maternity Home	2	1	—	Church of England
Liverpool—St. Monica's	1	—	—	Church of England
London—Clevedon House, Norwood... ..	1	—	—	Children's Aid Society
Mansfield—Grosvenor House	1	—	—	Voluntary Committee
Pontefract—"The Haven"	12	—	1	Church of England
Salford—St. Teresa's	1	—	—	Roman Catholic Church
Sheffield—St. Agatha's Hostel	23	2	—	Church of England
Sutton-on-Hull —Sutton House	1	—	—	Church of England
York—Heworth Moor House	16	—	—	Church of England
	174	10	6	

Towards the end of the year, it was agreed to extend from eight to thirteen weeks the period for which financial responsibility may be accepted for the maintenance of unmarried mother in moral welfare homes. The decision was taken having regard to the increasing numbers of applications being received for extensions on health grounds and to the fact that, under the provisions of the Adoption Act, 1958, a mother cannot complete the document signifying consent to the adoption of her child until the child is at least six weeks old.

The thirteen weeks exclude the fourteen days' normal lying-in period but, where—exceptionally—the confinement takes place in the moral welfare home, financial responsibility is accepted for this additional period.

Premature Infants:

According to a nationally agreed definition, a premature infant is one which weighs 5½ lb. or less at birth, irrespective of the length of gestation. There were 2,291 premature births, of which 1,954 were live and 337 still. Of the premature live births, 26 per cent. were born at home and 74 per cent. in institutions. Of those born at home, 89 per cent. weighed 4 lb. or more.

THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1960 TO MOTHERS NORMALLY RESIDING IN THE WEST RIDING

ADMINISTRATIVE COUNTY AREA WHEREVER THE BIRTH TOOK PLACE

Total adjusted live births—27,935

Number of live premature births—1,954

Percentage of premature live births to total live births—7.0

Number born dead—337

Weight Group	Number of Premature Births					Number Dying														Number Surviving over 28 days					Percentage Survival 1960	Percentage Survival in previous years						
	Born Alive					First Week					Second Week					over 28 days																
	A	B1	B2	C	Total	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Over 14 up to 28 days	A	B1	B2	C		Total						
lb.																																
5—5½	204	10	244	332	790	32	9	1	4	3	1	—	1	—	—	1	—	1	—	—	201	9	240	318	768	97.2	96.4	95.7	96.0	96.1	97.4	
4½—5	153	4	112	213	482	46	14	3	5	—	—	—	—	—	—	—	—	—	1	148	4	104	201	457	94.8	92.9	92.9	92.1	91.7	91.5		
4—4½	58	1	63	143	265	38	16	6	5	1	1	—	—	—	—	1	—	—	—	57	1	54	123	235	88.7	86.9	89.9	85.7	89.4	90.3		
3½—4	38	—	42	71	151	45	15	3	3	1	—	1	—	—	—	—	—	—	1	33	—	33	61	127	84.1	84.8	79.3	81.0	74.8	76.5		
3—3½	23	—	18	54	95	53	12	4	3	—	2	—	2	—	1	—	—	—	1	19	—	12	38	69	72.6	60.9	65.9	54.8	68.0	66.3		
2½—3	12	—	18	31	61	44	23	4	3	—	2	—	—	—	—	—	—	—	1	4	—	9	14	27	44.3	40.4	40.9	39.4	43.3	45.8		
2—2½	6	—	9	26	41	33	18	3	1	—	—	—	—	—	—	—	—	1	—	4	—	5	9	18	43.9	27.9	26.1	20.0	19.1	29.3		
1½—2	9	—	5	30	44	31	35	2	3	2	1	—	—	—	—	—	—	—	—	—	—	—	1	1	2.3	4.2	10.9	9.8	2.5	4.2		
1½ and under	4	—	1	20	25	15	19	3	2	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	
Total	507	15	512	920	1954	337	161	29	23	12	7	2	3	—	1	2	—	2	—	466	14	457	765	1,702	87.1	84.7	84.7	83.3	83.6	85.9		

240

8

252

A —Born in Domiciliary Practice.

B1—Born in Private Nursing Home.

B2—Born in Maternity Home.

C —Born in General Hospital.

The weight groups in the first column of this table should be read as under :—

“ 5—5½ lb.” means “ Over 5 lb. up to and including 5½ lb.”

“ 4½—5 lb.” means “ Over 4½ lb. up to and including 5 lb.”

The remaining weight groups should be read in the same way.

FOLLOW-UP OF PREMATURE BABIES BORN IN 1949 TO MOTHERS NORMALLY RESIDENT IN THE WEST RIDING ADMINISTRATIVE COUNTY AREA

Total born 1,426

Number who have removed outside Administrative County or where
parents refuse to co-operate in the inquiry 298

1,128

Weight Group lb.	Period of Survival Number dying at following periods of life							Survived over 11 years
	Under 1 year	1 year and under 2 years	2 years and under 3 years	3 years and under 4 years	4 years and under 8 years	8 years and under 9 years	9 years and under 11 years	
5—5½	42	2	2	1	—	—	—	394
4½—5	33	2	—	1	—	—	—	217
4—4½	35	2	—	—	—	—	—	129
3½—4	33	—	—	—	—	—	—	67
3—3½	32	—	—	—	—	—	—	29
2½—3	33	—	—	—	—	1	—	14
2—2½	28	—	—	—	—	—	—	5
1½—2	19	—	—	—	—	—	—	—
1½ and under	7	—	—	—	—	—	—	—
Total	262	6	2	2	—	1	—	855
Percentage Survival	76·8	76·2	76·1	75·9	75·9	75·8	75·8	75·8

The weight groups in the first column of the table should be read as under:—

“ 5—5½ lb.” means “ Over 5 lb. up to and including 5½ lb.”

“ 4½—5 lb.” means “ Over 4½ lb. up to and including 5 lb.”

and so on.

Children Neglected or Ill-treated in their Own Homes—Prevention of Break-up of Families:

Throughout the Administrative County, there were 92 formal meetings of the Co-ordinating Committees established under the Chairmanship of the Divisional Medical Officer for the area to co-ordinate the activities of the many statutory and voluntary organisations concerned in the welfare of children. In 10 divisions, meetings were held quarterly or at more frequent intervals, and in 11 divisions, meetings were held less frequently than

quarterly, in four instances one meeting only being held; no formal meetings were held in the remaining five divisions but there was consultation between officers as the need arose in dealing with individual cases.

It is considered that the combined resources of the various agencies represented on the Committees can, when properly co-ordinated, give valuable assistance with problem families and, although in many cases little improvement can be hoped for or achieved, further deterioration can be arrested and the break-up of the family, which would otherwise be inevitable, avoided.

The following report, submitted by Dr. Hepple, Divisional Medical Officer, Harrogate (No. 8) Division, serves to illustrate the method adopted by his Committee to achieve co-ordinated effort in dealing with the problems presented.

“The Harrogate Social Workers’ Group was started on Wednesday, December 6th, 1950, its purpose being to provide an opportunity for Social Workers in all fields to become personally acquainted, to allow each social worker an opportunity to learn the extent of the field covered by the others and to allow for discussion of cases where overlap between many members had occurred and where advice could be sought.

At that time it was stated that its initiation was intended to cover a wider field than that suggested by the Home Office Circular concerning the care of children neglected or ill-treated in their own homes. On 12th October, 1960, the question as to whether the field should be restricted to families with children was considered and it was decided that in future it should. Discussion also took place as to the best method of reducing the number of workers visiting any one home, a constantly recurring problem. It was again reiterated that frequent personal contact by telephone or otherwise between individuals was the only satisfactory solution.

Meetings have been held at monthly intervals ever since 1950.

Three open meetings, to which a wider range of people were invited, took place in 1960 and, at these, talks were given on the following subjects:—

‘Housing and its Health Implications,’ by Mr. E. Dodsworth, Chief Public Health Inspector.

‘Mental Health in Childhood,’ by Dr. F. S. Schofield, Senior Assistant County Medical Officer.

‘The General Practitioner’s Point of View,’ by Dr. G. Johnson, a family doctor in the town.

The meetings were attended by representatives from the Welfare, Children’s and Housing Departments, Probation Officers, the Youth Employment Officer, School Welfare Officers, the Mental Health Social Worker, representatives from the N.S.P.C.C., the Ripon Diocesan Moral Welfare Association and the Guild of Help, the Almoner of the Harrogate General Hospital, the health visitors, and the Divisional Medical Officer and his medical staff.

Approximately 30 people attended the open meetings and an average of 12 were present at the case discussions. During the whole year, 31 families were reviewed—approximately 15 at each meeting, some being added and others dropped according to need. Two families have been under intermittent supervision since 1950, and two or three more for nearly as long.”

Reference was made in the 1959 Report to the joint circular of the Ministry of Housing and Local Government (17/59) and the Ministry of Health (4/59) which reviewed the problems presented by homeless families or by unsatisfactory tenants who may be faced with eviction.

In February, 1960, a conference was convened, at which housing authorities in the West Riding were represented, to—

- (a) review existing arrangements for dealing with homeless families and unsatisfactory tenants;
- (b) discuss the desirability of providing intermediate accommodation;
- (c) discuss the desirability of introducing a scheme for the guaranteeing by the County Council of rent deficiencies incurred by housing authorities in the housing of homeless families and unsatisfactory tenants.

The views and opinions and current practices of the various housing authorities differed so widely that the conference could not reach any definite conclusions on the points under discussion, and it was decided that arrangements should be made to convene separate conferences of the housing authorities in each divisional health area to which the Divisional Medical Officers and the Divisional Welfare Officers concerned would be invited.

These area conferences were eventually held but, from the reports received, it appeared that there was no great demand for assistance from the County Council in the provision of intermediate accommodation. At the same time, the County Council recognised their responsibilities as a welfare authority and were prepared to consider, on the merits of each case, the granting of assistance as each case arises. They did not feel that it was necessary at the present time to formulate a set scheme for the guaranteeing of rent deficiencies incurred by housing authorities in the housing of homeless families and unsatisfactory tenants.

In order to deal with applications received from housing authorities with the minimum of delay, the County Council established a special sub-committee which meets at approximately monthly intervals. Already assistance for periods of three or six months has been given in a number of cases and, during the period in force, the Divisional Medical Officer concerned is required, in concert with the Divisional Welfare Officer, to take such measures as he considers necessary within the services at his disposal with the aim of rehabilitating the family. It is becoming apparent, however, that the scheme is not working as satisfactorily as was envisaged and both members and officials of the County Council feel that there should be a new approach to the problem.

With few exceptions, the cases already considered are in respect of families where the parents are just bad financial managers and constantly in debt. They are not problem families in the generally-accepted sense, and rehabilitation measures are not likely to meet with any success. The Special Sub-Committee, while appreciating this, have, nevertheless, rendered assistance—perhaps with the financial consideration in mind in that it is much cheaper for the County Council to guarantee rents than to take children into care in the event of families being evicted from their homes.

Where assistance is granted in respect of cases coming within the usually-accepted definition of problem family, it is necessary that the County Council's services should be equipped to provide adequate rehabilitation measures.

While frequent surveillance by the health visitor is necessary, something more than this is needed—someone to work alongside the mother and, by example and encouragement, so improve her standards of housecraft, parentcraft and family budgeting until the mother is capable of caring for the home and family without assistance other than occasional visiting by the health visitor. Help of

this nature can be given within the scope of the existing Domestic Help Service and, early in 1961, the County Council agreed to the employment of carefully-selected domestic helps in the rehabilitation of problem families without charge to the recipient of the service. It was also agreed that, in view of the type of work to be undertaken and the measure of responsibility, domestic helps should receive a higher rate of pay than that applicable to the domestic help working in the normal type of household.

Day Nurseries:

The day nurseries which are available provide more than adequate accommodation to meet the established need, for reasons of health and associated socio-medical conditions, of the areas in which they are situated, but applications for admission on purely social grounds are continually being refused by the Divisional Medical Officers concerned to accord with the County Council's policy to admit only the following categories.

- (a) The young child whose mother is ill or having a baby.
- (b) The illegitimate child whose mother is required to work.
- (c) The young child of the widow who must educate and support her family unassisted.
- (d) The young child of the mother whose husband is ill.

There were six nurseries in operation, as was reported last year, namely:—

<i>Division Number</i>	<i>Day Nursery</i>	<i>Number of Places Provided</i>	<i>Average Daily Attendance</i>
3	Keighley	50	30
4	Shipley	50	30
8	Harrogate	40	27
15	Heckmondwike	40	28
18	Brighouse	40	27
19	Todmorden	40	13

The situation has remained under constant scrutiny by the Day Nurseries Sub-Committee and it was decided that the Todmorden Day Nursery be closed on 31st March, 1961, because of falling attendances.

The County Council also accepted financial responsibility for the accommodation of a further three children in day nurseries administered by the County Boroughs of Huddersfield and Bradford. At the end of the year, six children were in attendance at day nurseries administered by the County Boroughs of Huddersfield, Bradford and Leeds.

MIDWIFERY

The formation of Maternity Liaison Committees, as recommended by the Minister, was commenced towards the end of 1959 and completed during the present year. These meetings were advocated for the betterment of co-ordination and co-operation of the three administrative authorities providing the services, and there is no doubt that, from the many meetings which have been held, they are fulfilling the intention.

The Central Midwives Board, which governs the conduct and practice of midwives, amended a number of their rules in publishing their Twenty-Third Edition during 1960.

Institutional Midwifery:

Hospital accommodation was provided for 62 per cent. of the total births, an increase of 2 per cent. since 1958. However, this figure is misleading for, in that part of the County within the administrative control of the Leeds Regional Hospital Board, the percentage was 69 while, in the Sheffield Board area, the percentage was as low as 47. The inequity in the distribution of lying-in beds is illustrated in the following table.

Div. No.	Area	Population (estimated mid 1960)	Total Births (Live and Still)	Place of Birth			
				Hospital		Domiciliary	
				No.	%	No.	%
1	Skipton	80,690	1,188	992	84	196	16
3	Keighley	55,230	962	795	83	167	17
4	Shipley	67,200	1,146	865	75	281	25
5	Horsforth	112,990	1,793	1,421	79	372	21
7	Ripon	23,900	451	357	79	94	21
8	Harrogate	78,300	1,227	1,003	82	224	18
9	Wetherby	50,030	755	435	58	320	42
10	Goole	45,760	751	329	44	422	56
11	Castleford	60,290	1,036	670	65	366	35
12	Pontefract	60,010	1,157	719	62	438	38
13	Morley	84,190	1,487	928	62	559	38
15	Batley	48,380	874	717	82	157	18
16	Rothwell	56,920	888	476	54	412	46
17	Spenborough	49,170	791	646	82	145	18
18	Brighouse	57,960	921	561	61	360	39
19	Todmorden	54,250	822	480	58	342	42
20	Colne Valley	89,650	1,391	1,015	73	376	27
22	Wortley	89,410	1,454	968	67	486	33
23	Hemsworth	67,130	1,306	704	54	602	46
25	Barnsley	77,350	1,345	668	50	677	50
26	Wath upon Dearne	47,200	880	372	42	508	58
27	Adwick le Street	40,940	801	340	42	461	58
28	Doncaster	64,090	1,460	602	41	858	59
29	Thorne	34,770	736	313	43	423	57
30	Mexborough	63,780	1,147	447	39	700	61
31	Rotherham	92,370	1,919	840	44	1,079	56
Leeds Hospital Board Region ...		1,142,050	18,946	13,113	69	5,833	31
Sheffield Hospital Board Region		509,910	9,742	4,550	47	5,192	53
West Riding Administrative County		1,651,960	28,688	17,663	62	11,025	38

Domiciliary Midwifery:

At the end of the year there were 431 midwives being employed in the administrative county, as follows:—

266 by the County Council.

151 by Hospital Management Committees.

14 in private practice.

There were 10,932 deliveries attended by County Council midwives, of which 97 cases had contracted with medical practitioners for the provision of maternity medical services.

The following statutory notifications were received from midwives:—

Maternal death	2
Death of the infant	48
Still birth	178
Laying out of the dead	45
Liability to be a source of infection	144

As the Local Supervising Authority under the Midwives Act, the County Council are responsible for the supervision of practising midwives within the area and, for this purpose, two non-medical supervisors are employed. The following is a summary of their work:—

Consultations with Divisional Medical Officers and Divisional Nursing Officers	95
Practical visits to midwives	236
General visits to midwives	19
Attendances at labour	7
Attendances at ante natal and parentcraft classes	59
Attendances at group meetings	45
Visits of inspection at maternity homes	28
Visits undertaken with pupil midwives	31
Attendances at meetings of Maternity Liaison Committees	11

POST-CERTIFICATE INSTRUCTION:

Thirty-nine midwives attended approved post-certificate courses at the following centres: Birmingham, Bradford, Hull, Leeds, Newcastle and Sheffield.

TRAINING OF PUPIL MIDWIVES:

Twenty-eight pupil midwives were trained in the practice of domiciliary midwifery in accordance with the regulations of the Central Midwives Board governing second period training.

ANALGESIA:

Because of the increasing demand, both from midwives and patients, for the administration of trilene (trichloroethylene), the County Council have agreed to the provision of trilene apparatus as an alternative to gas and air. Training was given at selected hospitals to midwives not already acquainted with the administration of trilene, and arrangements were subsequently made for the apparatus to be provided to 245 midwives. By the end of the year, 90 trilene inhalers were in use, and the remaining machines were in the course of being supplied.

Two hundred and ninety-six gas and air machines were also in use at the end of the year. In addition, pethidine was administered alone or in combination with gas and air.

The following table indicates the extent to which analgesics as a whole were made use of within each administrative division.

iv. No.	Area					Percentage receiving Analgesia					
						Pethi- dine alone	Gas and air alone	Gas and air with Pethi- dine	Tri- lene alone	Tri- lene with Pethi- dine	Total
1	Skipton	...	...	...	...	6	25	47	0.5	0.5	79
3	Keighley	...	...	...	...	9	12	39	7	17	84
4	Shipley	...	...	...	...	1	14	69	1	6	91
5	Horsforth	...	...	...	...	6	25	53	1	2	87
7	Ripon	...	...	...	...	2	37	40	2	4	85
8	Harrogate	...	...	...	...	8	21	37	5	15	86
9	Wetherby	...	...	...	...	3	24	53	—	—	80
10	Goole	...	...	...	...	4	36	35	1	1	77
11	Castleford	...	...	...	...	1	59	17	4	2	85
12	Pontefract	...	...	...	...	17	16	47	1	2	83
13	Morley	...	...	...	...	5	29	50	1	2	87
15	Batley	...	...	...	...	13	6	42	2	19	82
16	Rothwell	...	...	...	...	17	22	36	3	9	87
17	Spenborough	...	...	...	...	1	22	54	2	5	84
18	Brighouse	...	...	...	...	2	17	63	1	5	88
19	Todmorden	...	...	...	...	7	23	45	3	6	84
20	Colne Valley	...	...	...	...	9	24	43	3	4	83
22	Wortley	...	...	...	...	25	15	19	2	6	67
23	Hemsworth	...	...	...	...	18	18	29	5	3	73
25	Barnsley	...	...	...	...	7	20	51	2	5	85
26	Wath upon Dearne	...	...	...	...	27	16	17	1	3	64
27	Adwick le Street	...	...	...	...	16	23	31	1	3	74
28	Doncaster	...	...	...	...	10	17	50	2	2	81
29	Thorne	...	...	...	...	30	6	26	1	6	69
30	Mexborough	...	...	...	...	6	29	41	3	2	81
31	Rotherham	...	...	...	...	22	8	21	2	11	64
Leeds Hospital Board Region						8	25	44	2	5	84
Sheffield Hospital Board Region						18	16	33	2	5	74
West Riding Administrative County						14	21	39	2	5	81

LYING SQUAD:

Arrangements are in operation from the undermentioned hospitals whereby emergency units are available for the domiciliary treatment of patients whose condition is too grave to justify immediate transfer to hospital. This service has, over the years, made a valuable contribution towards the reduction of maternal mortality.

- | | |
|--------------------------------|-------------------------------|
| St. Helen Hospital, Barnsley. | Maternity Hospital, Leeds. |
| St. Luke's Hospital, Bradford. | Montagu Hospital, Mexborough. |
| General Hospital, Halifax. | Jessop Hospital, Sheffield. |
| General Hospital, Harrogate. | General Hospital, Wakefield. |
| Royal Infirmary, Huddersfield. | |

HEALTH VISITING

Several steps were taken in 1960 to consolidate the scheme approved by the Committee in 1959 of the appointment of Divisional Nursing Officers, and the establishment was practically completed by the end of the year. Each person appointed to such a post spent a period of three weeks' orientation in the central office and in some divisions to enable them to understand the work, both at county as well as divisional level.

There is a national shortage of nurses, particularly in the field of health visiting. It is, therefore, all the more necessary to have someone in the divisions co-ordinating the nursing services, by allocating work to those most fitted to do it, to see there is no overlapping of services; by recruiting auxiliary personnel to assist trained workers to bridge the gap between field workers and the administrative staff; and to advise headquarters, through their Divisional Medical Officers, of the activities of the divisional nursing staff.

In this day and age when it is necessary for staff to be well-informed and when there is so little time for reading, the Divisional Nursing Officer plays a particular part in the educational programme of staff, keeping them up-to-date with current events in nursing policies and techniques through meetings and distribution of knowledge and through other channels which work towards better and more concentrated community care.

Divisional Nursing Officers' meetings have been held monthly in County Hall where interchange of information has taken place and guidance has been given where necessary. These meetings have been found beneficial both to the Divisional Nursing Officers and the County Medical Officer.

Innovations in any service nearly always bring teething troubles and this scheme has not been without them, but the first teeth have been cut with very little disturbance and it is hoped that the permanent set will have even less and we can go forward to the achievement of well-integrated county nursing services.

The second important step in 1960 was the appointment of Miss M. G. Edwards as Deputy County Nursing Officer, with a special interest and duty in the field of health education. A concentrated effort is being made in this branch of the work to assist the health visitors and other health teachers, such as the midwife and the home nurse, to give a better service.

The nurse, wherever she works—be it hospital or domiciliary, is a teacher helping people to recognise their health needs and assisting them to attain mental and physical well-being. We look to the future when, with the help of Miss Edwards, the nursing staff will be better equipped for carrying out the work of health education in the domiciliary field.

A more detailed account of the work in health education will be found on page 115.

Work with the aged has again increased and many health visitors, whilst appreciating the necessity for visiting and enjoying it because it is worth while to do—on the other hand—begrudge the time spent on this work because of the heavy case-loads of other problems at the younger end and in the family groups. Visiting the aged is time-consuming but it is difficult not to spend longer with them than one can afford.

Much has been said about the work of a health visitor as a social case worker. At the moment, it is not possible to tackle the health visitor's problems from that aspect because her case-load far outweighs that of any other social worker.

There has been a general increase of home visiting during 1960; the number of families visited has increased by 3,794 and visits to children under the age of one year by 7,796. The latter may be due to additional visits to the home by the health visitor doing the phenylketonuria tests of which a report appears elsewhere.

An analysis of the work undertaken is shown below:—

Number of families visited	...	...	...	...	...	...	93,133
No. of children under five years of age visited	...	...	...	...	...	...	88,982

Analysis of Visits

Expectant mothers	...	...	...	...	...	...	9,688
Children under 1 year	...	...	...	...	...	152,666	
aged 1—2 years	...	...	...	...	...	73,992	
aged 2—5 years	...	...	...	...	...	110,292	
						<hr/>	336,950
Tuberculous households	...	...	...	...	...	...	9,041
Other cases	...	...	...	...	...	...	181,578
School health	...	...	...	...	...	...	20,538
Ineffective	...	...	...	...	...	...	49,696
						<hr/>	
						Total	607,491
						...	<hr/>

Clinic and School Sessions

Maternity and Child Welfare	...	...	...	...	...	...	27,483
Ultra Violet Light	...	...	...	...	...	...	1,944
Parentcraft	...	...	...	...	...	...	1,002
Specialist—Chest	...	...	...	...	...	...	2,547
Other	...	...	...	...	...	...	3,016
School Health	...	...	...	...	...	...	18,203
						<hr/>	
						Total	54,195
						...	<hr/>

The present staffing establishment for health visiting, school nursing and tuberculosis visiting is 341 whole-time officers. At the end of the year, 330 staff (equivalent to 309 whole-time officers) were employed on these services 2 less than the previous year), made up as follows:—

Qualified health visitors (5 part-time) combining the duties of health visiting and school nursing.	246
Assistant health visitors (28 part-time) without the health visitors' certificate, combining duties in the public health and school health services, 14 of whom also undertake health visiting under dispensation granted by the Ministry.	72
Whole-time school nurses.	3
Qualified health visitor combining the duties of health visiting, school nursing, home nursing and midwifery.	1
Whole-time tuberculosis visitors.	8
	<hr/>
	330
	<hr/>

There were 43 appointments, 45 resignations, 9 retirements and 1 death.

Post certificate Training:

Thirty-nine health visitors attended approved courses organised by the Women Public Health Officers' Association and the Royal College of Nursing. These have been appreciated by the health visitors who had the opportunity of attending.

Another in-service training course was held at Grantley Hall, the subject being "Childhood to Maturity." It was attended by 42 County Council health visitors and two from Wakefield County Borough. Professor W. S. Craig gave the inaugural lecture, and he was followed by other eminent speakers on "Nutrition in Childhood," "Minor Ailments," on to "The Causes of Aggression in the Modern Youth" and, finally, to "The Care of the Aged."

Six health visitors attended a two-day course held in Wakefield by the Central Council for Health Education.

Twenty-four health visitors attended a course on screening tests on ascertainment of deafness in young children. This course was held in the Morley clinic and a lot of work was put in by the nursing staff there in arranging for sufficient mothers to attend with children to be tested.

Student Health Visitors:

The problem of recruitment of suitable candidates to take the course was again very marked and, although many applications were received, only 11 were accepted for training under the County Council's scheme. Of these students, 12 passed the Examination of the Royal Society of Health at the first attempt and the remaining student has since been successful. These results would appear to justify the standards set by the Selection Committee whose task becomes increasingly difficult when confronted with the choice of quality versus the national staff shortage.

Success in examinations is no real criterion of ultimate success in the work so that, during the course, every effort is made to imbue the students with the feeling of the overall value of preventive medicine and to put it in its proper perspective when compared with the glamour and excitement of hospital or other fields of nursing. In lectures and tutorials, the historical aspect of public health work can be stressed and comparisons made between conditions in the nineteenth century and the present, but it is in the field worker's optimistic approach to the day-to-day problems that the student realises how much assistance is needed by and can be given to the community. Therefore, it is most important that the health visitor chosen to undertake the practical training of the student should be someone with the personality, knowledge and understanding necessary to both encourage and teach the student, whilst still maintaining her friendly contact with her families. This can be quite difficult as it is obvious that the practical training must infringe upon the amount of routine work the health visitor is able to accomplish. Despite these difficulties the students have never been rejected for practical training, and we owe a debt of gratitude to the many health visitors who valiantly accept this onerous duty.

During the 1959-60 course, the Ministry of Health Inspectors visited and were impressed by the variety of practical training offered in the area. Apart from one or two recommendations, the theoretical aspect of the course is to continue on much the same lines as in the past. The biggest change suggested was that the practical training might be undertaken in a block, thus saving travelling time and allowing for a more concentrated approach to the work of the health visitor.

HOME NURSING

Staffing:

There has been no difficulty in obtaining home nursing staff during 1960. The establishment remains at 290, and 310 (whole-time equivalent 267.2) home

nurses were in employment at the end of 1960, which was an increase of eight from the previous year. These were made up as follows:—

Home nurses, S.R.N. (4 part-time) ...	...	222
Senior relief home nurses, S.R.N. ...	...	1
Senior relief home nurse/midwives, S.R.N.		3
Home nurse/midwives, S.R.N. (1 part-time)		71
Home Nurses, S.E.A.N. (2 part-time) ...	...	9
Village nurse/midwives, S.E.A.N. ...	...	4
		<hr/>
		310
		<hr/>

New appointments numbered 36; these were whole-time home nurses. There were 27 resignations and one retirement.

Training:

The Ministry of Health national training scheme for home nurses commenced in 1960. Some of the training homes used in the West Riding commenced with the new training in May and the rest in September. Queen's Institute training homes have now adapted their syllabus to dovetail with that of the Ministry, and all students attending these training homes will obtain both certificates. There were 13 students trained during 1960.

Arrangements were made for 48 students from the training homes to have three days' experience with selected home nurses in rural communities.

Cars:

Two hundred and sixty-seven nurses use cars in connection with their work and, in 76 cases, the car is provided by the Authority.

Refresher Courses:

A refresher course was held at Grantley Hall in the middle of July, with an attendance of 43 County Council students and four part-time students from Wakefield City. The main feature of this course was the move towards new practices and treatments in hospital. Mr. Wooler, Thoracic Surgeon, Leeds General Infirmary, gave an inspiring talk on chest surgery, whilst Dr. Nuttall, Director, Radiotherapy Department, Cookridge Hospital, spoke of the modern trends in cancer treatment. Professor Tunbridge spoke on the diabetic patient and Dr. Rosenthal, Geriatrician, on the care of the aged. Three observation visits were arranged to link up with the lectures. These were to the Geriatric Unit of St. James's Hospital, the Chest Surgery Department of the Leeds General Infirmary, and Cookridge Hospital, Leeds.

This refresher course and the hospital visits, which gave the home nurses an insight into present day hospital techniques, were greatly appreciated by them.

Injection Therapy:

Thirty-two per cent. of the total visits made by home nurses were for the purpose of giving injections—a decrease of 4 per cent. on the figures for 1958 and 1959. In some areas, there was a slight increase, but—in others—the decrease was considerable. A further decrease is to be expected when more use is made of drugs which can be given orally. This gives the home nurse more time for nursing the sick and aged and for the propagation of health education.

Summary of the Work of Home Nurses:

The total number of cases dealt with by the home nurses was 31,305 compared with 32,855 for 1959—a decrease of 1,550, whilst the total number of visits has increased by 4,599—from 782,963 to 787,562. The main group where extra

care has been given was in the aged category which will account for the increased number of visits. Dr. Ward, Divisional Medical Officer, Division No. 20, reports:—

“ The number of patients attended was 79 less than in the previous year but the number of visits paid was 1,676 more than in 1959.

An analysis of these figures shows a slight reduction in medical cases, which include the aged and chronic sick, and an increase in surgical and tuberculosis nursing. There were 16 cases less in the 65+ age group but 986 more visits were paid to them. There was also a sharp reduction—716—in the number of visits made for injections only.”

Dr. Caithness (Division No. 15) reports:—

“ 56·5 per cent. of all new cases were 65 years of age or over. Many of these patients are bed-ridden or severely physically handicapped and form a heavy load in the nurses' work.

At one period of the year, there were seven elderly diabetic patients requiring daily visits for insulin injections, thus taking up 49 visits per week. These patients were quite unable to be trained to give their own injections by reason of age and physical incapacity and no other relatives were available.”

It is difficult to envisage any appreciable decline in the number of cases (or trend in this direction) in the future; indeed, one would expect the number to increase, particularly in view of the shortage of hospital beds for geriatric patients.

There is a close link between the general practitioner and the home nurse, and every effort is made to assist the field workers in providing the best type of nursing aids. Aids, such as the P.C.P. mattress and the Ripple bed, are being experimented with, and the nurses have been very helpful and co-operative in sending in reports about new equipment.

Although the majority of the work is with the aged, more acute work would be welcome and give a more varied experience to the nurse. A closer co-operation with hospitals could lead to earlier discharge of post-operative cases, and many people travel far to attend hospital out-patient departments for dressings which could be done by home nurses either at home or at the nearby clinics.

The following table gives details of the numbers and types of cases visited by home nurses.

<i>Type of cases attended</i>							<i>No. of cases attended</i>	<i>No. of visits by Home Nurses</i>
Medical	...	...	...	...	...	...	23,135	613,683
Surgical	...	...	...	...	...	...	7,377	137,892
Infectious diseases	...	...	...	...	...	...	31	379
Tuberculosis	...	...	...	...	...	...	441	32,328
Maternal complications	...	...	...	...	...	...	321	3,280
Total							31,305	787,562
<i>Age Groups</i>								
0—4	...	...	...	...	...	...	1,460	11,945
5—65	...	...	...	...	...	...	12,416	259,140
Over 65 years	...	...	...	...	...	...	17,429	516,477
Total							31,305	787,562
Patients included in the above who have had more than 24 visits during the year							5,769	388,724

AMBULANCE SERVICES

The Service is under the charge of Mr. V. Whitaker, O.B.E., and I am indebted to him for supplying the following report:—

				Year ended December 31st		Variations on 1959	
				1959	1960	Increase	Decrease
Admissions	...	...	...	44,860	44,729	—	131
Discharges	...	...	...	27,893	27,054	—	839
Transfers	...	...	...	10,996	11,320	324	—
Out-Patients	...	...	...	362,518	385,686	23,168	—
Accident and Emergency	...	...	...	11,542	11,836	294	—
Total of Direct Services	...	...	...	457,809	480,625	22,816	—
Total of Direct Service plus Agency and Car Pool Services	...	...	...	485,473	511,887	26,414	—
Mileage of Direct Service	...	...	...	3,023,367	3,100,801	77,434	—
Total Mileage (including Agency and Car Pool Services)	...	...	...	3,325,883	3,394,127	68,244	—

The two minor increases concern inter-hospital transfers and also accidents and emergencies. The latter demand has followed the rising trend in the number of road accidents. The principal increase has been in connection with the conveyance of out-patients and is attributed to a large extent to the new demand for the transport of geriatric and psychiatric patients to “ day hospitals ” and special clinics. Indications are that these “ day cases ” will continue to increase as geriatric services expand. This may lead to a need to review staff and vehicle establishments at certain stations as the twice daily transport of these cases on a time basis, which coincides with the peak of general demand, is becoming increasingly difficult to accommodate.

Although the work of the service continues to increase annually, such increase compares favourably with the national average which, over the past five years, has been 16·48 per cent. patients and 6·60 per cent. in miles against the County Services increases, over the same period, of 11·48 per cent. for patients and 4·1 per cent. in miles. A careful analysis and control of hospital requisitions carried out over the last few years has helped to keep the increase reasonable.

One important feature is that despite the increased demand on the service it has been possible to continue the policy of carrying stretcher case admission and discharge patients individually or confined to not more than two of the same sex in a vehicle at one time. This practice ensures a most speedy and comfortable journey for patients who need special care and attention between home and hospital.

Some two years ago, Leeds General Infirmary placed facilities at the disposal of the Ambulance Service for the storage of exchange ambulance equipment. Through this arrangement, stretchers, carrying sheets, blankets, etc. are left with patients taken to the hospital by ambulance staff, who then take replacement items from the exchange equipment store. This procedure has resulted in a great saving of time ambulance staff would otherwise waste in waiting for equipment to be released by the patient receiving department. It is now proposed, wherever possible, to make similar arrangements with other hospitals and also seek the co-operation of other ambulance services operating into the same hospitals.

Another successful experiment has been in connection with the ordering of ambulance transport which, in the past, has been on the basis of stretcher or sitting cases. Patients of Leeds General Infirmary and St. James's Hospital are now classified as "Stretcher," "Double-Handed Sitters" or "Single-Handed Sitters." This procedure ensures the despatch of the right type of vehicle and also overcomes a past difficulty when a driver only sent to convey a sitting case found the patient, though able to sit in a vehicle, was unable to walk and needed the assistance of a driver and attendant.

The two experiments are the result of close co-operation with the hospitals concerned which also have Ambulance Liaison Committee Meetings twice a year to discuss patient transport problems. Much has been done through this medium to the benefit of patients and the two services.

Delivery has been taken of 21 new vehicles built to a specification incorporating the latest in body design and construction, including a wrap-round windscreen for maximum visibility. Special springing has also been fitted to provide the best possible riding qualities.

It is interesting to note the effect on fuel costs of the policy of operating a vehicle fleet comprising approximately 48 per cent. diesel and 52 per cent. petrol units, in that the overall fuel cost per mile in 1959-60 was 2¾d. compared with 4d. per mile for 1954-55.

The policy of grouping stations for the reception of night and week-end calls at one central point in each group continues. The working of the two groups already established with reduced telephone staff has proved satisfactory.

A further two new Ambulance Stations have been completed and occupied at Brighouse and Skipton respectively. The adaptation of the premises at Honley has also been completed and they will be occupied as soon as the necessary telephone facilities have been provided. New office and staff accommodation at Keighley and garage accommodation at Settle has also been provided, making a total of 17 new and modernised stations. A new station at Menston to replace the temporary premises at Guiseley is nearing completion. Provision has been made for the erection of a new station at Bramham and the transfer of Garforth station to new premises at Sherburn in Elmet. The latter site is more central to the patient catchment area and is better situated to provide accident cover on a nearby stretch of the new A.1 dual carriageway. Work is due to commence in the near future on new garage and toilet accommodation at Pudsey.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

The education of the public in matters relating to health has been one of the primary concerns of Health Departments since their inception in the 19th Century. In the 73 years since the West Riding County Council was set up, the practice of health education has changed as the need has arisen and circumstances allowed. Thus, initially, the approach was limited to individual advice given by health visitors to people in their own homes. Later, when Infant Welfare Clinics were set up, the scope was widened to include the advice given by doctors. With the introduction of school hygiene and medical inspections and minor ailments clinics, it became possible for doctors and nurses to give group talks on topics relevant to the maintenance of health amongst school children. As the activities of the Public Health Department have increased, the scope of health education has continued to grow and the county is very actively concerned with programmes for the dissemination of knowledge on health matters to such groups as expectant and nursing mothers, prospective fathers, school children, youth groups, teachers' training colleges, parent/teacher associations and many voluntary organisations of all kinds. The group that is virtually left out and which requires a great deal of guidance in matters relating to health is the group of people who leave school at 15 years of age. There is a very real problem here, as there is lack of contact, but efforts are necessary to overcome this difficulty.

One of the biggest difficulties facing the health teacher is that of apathy amongst the general public towards matters relating to health and to overcome this every suitable device of arousing interest in this subject must be considered. This is not an easy task, as there is no concrete visible "end product," which appears to be such an essential part of our present materialistic world. In the scholastic field it has long been accepted that the spoken word alone is unreliable in retention and perception and, to overcome this, visual aids are used. Teaching aids are also playing an ever increasing role in health education generally and this is seen in many of the reports from the Divisional Medical Officers. To quote a few: Dr. McDonagh, Division 3, writes: "During the past year numerous film strips were shown on, for example, vaccination and immunisation, poisonous berries, normal emotional and physical development of the child . . . , etc. The display of pegboards and other exhibition material in the clinics has varied throughout the year and provided a source of interest." From Division 4, Dr. Battersby reports: " . . . sound films and film strips have been shown, posters displayed, leaflets distributed and a pegboard triptych goes the round of the clinics." Dr. Douglas states that in Division 17 there are permanent displays on a variety of topics at the main clinic centres and use is made of leaflet material.

From these few extracts it is clear that there is an increasing demand for suitable visual and audio-visual aids in the field of health education and it is important that such aids should be accurate, artistic and acceptable, comparing favourably with the high-powered advertisements of our era.

Some of the teaching aids already available for use in the county include sound film and film strip projectors together with a collection of film strips, flannelgraph material on various subjects and pegboards with suitable display material. In addition, during 1960, some 92,000 leaflets and 17,200 bookmarks

were distributed whilst 5,337 posters, 53 picture sets, 1,000 labels and 1,790 "Dayglos" strips were displayed. This literature was also made available, where required, for use in schools, libraries, doctors' surgeries etc. Propaganda against venereal diseases was maintained and 700 perspex covered notices giving the addresses and telephone numbers of the Special Treatment Centres were displayed in supervised public conveniences, at large factories and railway stations.

The teaching aids available were taken into consideration when programmes of health education were planned at the divisions for the ensuing year. The production of these programmes has proved most valuable, enabling the staff to prepare talks to specific groups on varying topics and also to stress the particular theme in their advice to individuals in their own homes, thus making a more concentrated effort possible. It has also meant that, where appropriate, correlation of "local" and "national" campaigns has been planned and achieved. An example of this was seen during Mental Health week, 9th-16th July, 1960. Dr. Battersby writes: "A one day Mental Health Exhibition was held at Victoria Hall, Shipley, to help educate the public into a new understanding of mental health and illness. Dr. R. W. Elliott attended, opened the exhibition and gave an address." Dr. Cusiter, Division 26, also tells us that: "... an exhibition was staged during Mental Health Week. During this period films were shown and an exhibition of handicrafts made by mentally disordered people was arranged. Talks were given by Miss D. Walker, County Nursing Officer, and by a social worker, and later a Brains Trust Panel sat under the Chairmanship of the Divisional Medical Officer. The whole exhibition was very much appreciated."

Several Divisional Medical Officers report the formation of new parents' clubs where talks, discussions, film shows and such activities take place covering many and varied subjects, the stress always being on matters relating to health.

There is still much cause for concern in relation to cigarette smoking and lung cancer. It would appear that the most important and most difficult group of persons to educate is the young adolescent, but education of parents is still a necessity. Where the young are concerned, it is obvious that what is likely to happen in 20 years' time is too remote a thing over which to worry and, to quote Dr. Appleton, Division 18: "They seem to consider that anyone of 50 years of age has already enjoyed all of life worth living." Divisional Medical Officers and their staffs have been untiring in their efforts to stress the dangers of smoking and have used the many charts, films and other material available on this subject in giving talks to a wide variety of audiences including school children, as can be seen from the following extract from Dr. Appleton's report: "All the Senior Schools have been visited and talks given to 13 year olds on the connection between Smoking and Lung Cancer and on the adverse effect of smoking on sporting activities. Very often the children contribute to the subsequent discussion. It is apparent in these discussions that unless the child is particularly good at sports the greatest deterrent to smoking is expense. The children whose parents themselves are heavy smokers, and do not mind their children helping themselves, do not benefit by this deterrent. Unfortunately, smoking goes with odd clothes and coffee-drinking as a desirable habit for teenagers and as a sign of adult status. Girls seem to prefer a boy who smokes and a non-smoker seems to be regarded as a nonconformist to juvenile traditions."

There is much variation in the amount of health education carried out by the Public Health staff in schools. In some Divisions, health visitors undertake a routine series of talks together with the showing of films and the use of demonstration methods of teaching to senior school children; in others, one or two specific talks and demonstrations are given. Instances of the variations are seen in the report sent in by Dr. Barnes, Division 25, who says: "A complete course of lectures comprising general health and hygiene, parentcraft, first-aid and home nursing, covering the whole year is held in the following schools: Wombwell, Darton, Darfield and Worsbrough Dale. At Cudworth a course of parentcraft only has been arranged—all other subjects are covered in the existing curriculum. At Dodworth a course of five lectures on general hygiene and nutrition has been given." In a third category, entry to the schools is given only for medical and hygiene inspections.

Further reference to health education in schools may be found in Part VII on page 202.

Many more Home Safety Committees have been formed during the year and, in most areas, either the divisional medical officer or a health visitor is included on these committees; their advice and help has been much appreciated. In some areas, exhibitions have been planned stressing the need for safer homes and also spotlighting the chief hazards likely to be found in each room. Again, these exhibitions have been arranged to take place locally at the same time as the Royal Society for the Prevention of Accidents launches their national campaign. It is interesting to note that the Aireborough Committee was set up at the instigation of the Rotary Club and meetings are held in accommodation provided by the Urban District Council. Dr. Burn, Division 5, states: "Their programme has consisted of education of the actual members of the Committee by experts in the problems of home safety, so that as wide a panel of speakers as possible could be developed, and some talks have been given to Old People's Clubs. The Otley Committee was formed by the Council of Women's Organisations and put on a very good exhibition at Easter."

One of the problems associated with the promotion of health education is the lack of suitable premises or space at some clinics. Gradually this difficulty is being overcome as a result of the building programme in hand at present. Another factor which mitigates against active participation in health education of groups has been the lack of effective teaching material and scarcity of time to prepare demonstrations and displays. Many visual aids have been made by health visitors but this is extremely time-consuming and not all such efforts are sufficiently attractive or explicit to warrant the time spent on their production. An endeavour to overcome this difficulty has been made by the appointment of an officer combining the duties of Deputy County Nursing Officer with that of responsibility for the promotion of health education programmes. This appointment is the result of the ever increasing activities of the county in the field of health education and is in accordance with the Ministry of Health Circular 26/59. This officer assesses and advises on the value of certain teaching aids, assists in the preparation of syllabuses for the many and varied groups and is available to take part in the giving of lectures and talks. It is hoped to build up a library of material at county level, which will be suitable for various demonstration and exhibition purposes. With so many avenues of approach available to the health teacher, it is important that every line and type of visual aid be investigated so that economy of staff time and energy, and also of material, is effected.

Because of the abstract nature of the ultimate goal in health education, an assessment of the value of methods in relation to cost can often only be made by relating the scheme to the cost of illness or hospital beds. In the introduction to the 1949 Annual Report for the West Riding County Council, the County Medical Officer outlined such an assessment in regard to the scheme of diphtheria immunisation stating that the over-all saving was to the value of £10,000 more than the cost of the whole of the Health Visiting Service in the County. This gives the cost in terms of finance but one must not discount the importance of mental and emotional well being. To-day, these aspects of health are receiving more attention and health teachers must be prepared to re-orientate their approach to problems. The balance of attention given to subjects and to specific groups needs to be viewed in the light of new developments in both medical and scientific fields. An example of this re-valuation might be found in giving to the adolescent an understanding of civic responsibilities, which should provide the basic elements for good citizenship and codes of behaviour. This teaching, when correlated with the subject of epidemiology, would place promiscuity and venereal diseases in their proper context.

Methods likely to provide effective health education in the future will include many of the ones in use to-day but the health teacher must always be alert to the need to introduce new media for the communication of information on this most vital aspect of public health work.

Recuperative Home Treatment:

Four hundred and ninety-one applications for recuperative home treatment were received as compared with 501 in the previous year. One hundred and twenty-seven cancellations represented 25·9 per cent. of the applications, and, of the remainder, 364—99 men and 265 women (24 with children)—were admitted to one or other of the under-mentioned homes. Four were on the waiting list at the end of the year.

Beachways Convalescent Home, Southport; Binswood Short Stay Rest Home, Didsbury, Manchester; Blackburn and District Convalescent Home, St. Annes-on-Sea; Boarbank Hall, Grange-over-Sands; Brentwood Recuperative Centre, Marple, Cheshire; Chest and Heart Association; Claremont Convalescent Home, Matlock; Elizabeth Fry Home, York; Evelyn Devonshire Convalescent Home, Park Hall, Buxton; Hunstanton Convalescent Home, Hunstanton, Norfolk; Metcalfe-Smith House, Harrogate; Shoreston Hall, Seahouses, Northumberland; Stubben Edge Hall, Ashover; Tudor Convalescent Home, Bridlington; Yorkshire Foresters' Convalescent Home, Bridlington.

Provision of Nursing Equipment in the Home:

14,855 items of nursing equipment were issued to patients being nursed in their own homes, an increase of 153 over the 14,702 items issued in 1959. The following schedule shows the wide range of equipment which is now made available and which is being increased each year:—

Item	Number on loan	Number avail- able for issue	Total	Number of issues during year
Bath lift	1	—	1	1
Bath seat	1	—	1	1
Bedding: blankets, pillows and cases, sheets, etc.—pieces	1,321	157	1,478	1,482
Bed blocks	9	147	156	9
Bed cradles	198	116	314	422
Bed pans	881	652	1,533	3,126
Bed rests	460	265	725	1,208
Bed tables	4	12	16	9
Bedsteads: hospital, with self-lifting pole, and other	223	7	230	304
Chairs: geriatric, relaxing, high rest, "Amesbury" play, stairway (carrying)	21	6	27	25
Commodes: chair and other	267	4	271	461
Cushions: air and "Dunlopillo"	60	39	99	176
Enuresis alarms	63	2	65	129
Fracture boards	28	1	29	40
Hemiplegic Exercisers	2	—	2	2
Hot water bottles	12	126	138	23
Lifting hoists	14	1	15	15
Lifting pole and chain	7	1	8	7
Mattresses: air, biscuit, "Dunlopillo," hair, water, "P.C.P.," flock, spring-interior	302	23	325	464
Open-air shelters	8	9	17	8
Pressure rings: air and foam rubber	547	633	1,180	1,741
Rubber sheets	1,007	526	1,533	2,607
Sputum mugs	46	292	338	74
Tables: "Amesbury," play	1	—	1	1
Urinals: male and female	534	837	1,371	1,539
Walking aids: 'Amesbury,' 'Bonaped,' 'Zimmer,' 'Companion,' crutches, tripod, walking sticks	212	126	338	290
Wheel chairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	319	42	361	691
	6,548	4,024	10,572	14,855

Liaison with the Hospital Service and General Practitioners:

More thought is being given as to what is meant by after-care and what are the objects of such care. The first object is to restore the patient to normal or to re-integrate him back into family life, and the second is to give the patient sufficient knowledge about his own illness to enable him to adjust and cope with whatever is in store for him. The third should be to give a sympathetic understanding to every individual.

If the growth of community care is to expand, then it is essential that all three services—hospital, general practitioner and local authority—must work together with the same objects in mind. The trend is towards this, and the time may not be far distant when every patient leaving hospital will have some information about his malady, and be assisted in his rehabilitation before discharge. This, together with the after-care given by the general practitioner and local authority services together, and re-visits to the hospital for periodic check-up (including, in some cases, a day therapy unit), should go a long way to give patients the benefit of a fully-integrated service. Progress has been made in the past year, but much remains to be done, not only by the general practitioner and local authority but also by the hospital. A general recognition of

the part each individual worker plays in this field now seems to be known, and there is every hope for the greatest possible degree of co-operation in the interests of the welfare of the patients.

An appreciable amount of work is being done by some health visitors in visiting patients in hospital wards with the object of helping to solve certain social or environmental problems to assist in rehabilitation, but care must be taken in the referral of these cases so that the health visitor only deals with those patients needing her help.

GERIATRICS:

Liaison in this field is developing rapidly. Almost every division has a programme for liaison with their particular hospitals, chiefly through the health visitor or Divisional Nursing Officer. In the existing scheme at Pontefract, an additional health visitor for the Castleford area has been delegated to do liaison work because of the large number of aged in the division. This is now working satisfactorily and allowing each health visitor to do some generalised health visiting. The demand for hospital beds in Pontefract is stated to be increasing. Miss Parrott of Hemsworth states:

“The problem of discharging patients is still a very real one. No longer is hospital care required, but a certain amount of help is needed. This need is not met by the domestic help as she does not attend week-ends and Bank Holidays, nor does she do any evening work.”

A “day hospital” has also commenced at the Headlands Hospital, and Miss Parrott says of this:

“A ‘day hospital’ is much used for doubtful cases. They are transported to the hospital two days per week; meals are provided, and they attend occupational therapy. In some cases, where the patient arrives dirty and neglected, a bath is given.”

In the Brighouse area, liaison work has recently started with St. John's Hospital, and Dr. Appleton, Divisional Medical Officer, reports:

“The Divisional Nursing Officer attends regularly at St. John's Hospital and, under a recent liaison scheme, since the appointment of a new Consultant, background reports are discussed with him by the Divisional Nursing Officer.”

Dr. Ward, Divisional Medical Officer, Division No. 20, also states:

“Close relationship with the staff of the Geriatric Unit at St. Luke's Hospital, Huddersfield, is gradually being developed in spite of occasional complaints that patients suitable for transfer to Part III Welfare Homes are not found accommodation when fit to be moved.”

More Geriatricians appear to be using health visitors for assessing the urgency of a case to be admitted to hospital, as in Batley where Dr. Caithness, Divisional Medical Officer, reports:

“This work is in the hands of one health visitor who, immediately on receiving the name of the patient, visits the home and submits the report of the home conditions on a special form.

It includes in the final paragraph the health visitor's opinion on the urgency of the case. Cases which are not considered immediately urgent are followed up at monthly intervals. In recent weeks, owing to the pressure on hospital beds and the rising demand for admission of a number of more serious cases, the health visitor has communicated with the hospital by telephone to indicate from week to week the most serious cases on her list. In the majority of cases which are reported urgent or very urgent, the patients have been admitted to hospital within two or three days.”

In the light of this, I think we may be fairly satisfied that progress is being made in the care of the aged.

DIABETICS:

The care and after-care of the diabetic patient is only working satisfactorily where the Consultant is keen to have this work carried out. In many areas, there is no liaison but, in the Colne Valley (No. 20) Division served by the Huddersfield Royal Infirmary, it is excellent. Todmorden and Brighouse have a scheme, as has Wakefield. The liaison work with diabetics in Castleford appears to be growing, and Dr. Paterson, Divisional Medical Officer, reports:

"The majority of patients adopt a sensible and co-operative attitude to their condition and appreciate assistance given them; on the other hand, a few patients are difficult and unready to follow advice given by either hospital or health visitor. These are specially listed and every effort is made to induce a reasonable attitude. Good liaison exists between hospital and health visitor, and the various statutory and voluntary bodies have been extremely co-operative. National Assistance allowances have been obtained for those who could not afford the diets ordered, while the Chiropody Service has been of especial benefit to diabetic sufferers."

MATERNITY:

In most instances, there is very good two-way traffic in the exchange of information between local authority staff and hospitals in relation to the discharge of mothers and babies, but there are times when a maternity unit is busy and desirous of discharging patients quickly at an early date. Sometimes the home conditions are unsuitable and no time is given for a report. In many areas, the health visitor visits the maternity unit and, in these instances, is able to advise the hospital personnel on the advisability of early discharges.

PREMATURE BABIES:

In almost every division there is liaison with the hospital staff over the care of premature babies, and, where a health visitor visits the maternity hospital, the care of the premature infant falls into perspective, and the necessary precautions are taken and background reports given. The scheme started with Professor Craig between Leeds Maternity Hospital and the County Council is progressing, and satisfaction has been expressed by Professor Craig on the good work done by the health visitor. Miss B. S. Smith, who visits Leeds Maternity Hospital, reports:

"In the course of this work, I visit the premature baby unit twice weekly—on Tuesday mornings to attend a ward round with Professor Craig and on Thursday afternoons to run a follow-up clinic. I think there is an average of four to five babies a week in the hospital from the West Riding.

The ward round is attended by medical students, pupil midwives, the Leeds premature baby nurse and myself. All cases are discussed and discharges arranged with regard to home conditions. If these are poor, the Professor will always keep the baby as long as possible, providing there are enough cots. In addition to premature babies, Blackburn ward admits all anomalies and any baby ill during the neonatal period. I obtain home reports by contacting the health visitor concerned by telephone and then submitting a written report to the hospital. We also keep the hospital informed about the state of the mother's lactation so that substitution of a dried milk can be made in good time or the mother invited for re-admission to establish breast feeding.

When a baby is to be discharged, I notify the Divisional Health Office, letting the health visitor know if there is any special treatment required.

The clinics are well attended by West Riding mothers who come from as far as Goole and Settle. Reasons for follow-up include prematurity, congenital heart lesions, hæmolytic disease, severe asphyxias and many other abnormalities. Referral to other hospitals or authorities are made as necessary."

There is no other scheme quite like this one in Leeds, but good work is being done elsewhere by contact between health visitors, midwives and hospital personnel.

CHILDREN:

The care of children is continuing in much the same way in most areas. Dr. Caithness writes in his report:

“Increasing co-operation has been established with the Consultant Pædiatrician, particularly with regard to reports on home circumstances and reports from head teachers of schools. In the opposite direction, a number of reports on or findings in educationally subnormal children have been conveyed to the Pædiatrician where these children are already in attendance at hospital for physical ailments or behaviour problems; thus a very helpful two-way exchange of information has been taking place throughout the year.”

In other areas, notification of discharges of children is usually sent to the local authority and to the general practitioner.

Chiropody Treatment:

The Authority's scheme, formulated under Circular 11/59 of the Ministry of Health, commenced in February, 1960. Full details of the scheme were published in the 1959 Report and a brief outline only of the arrangements is necessary in this Report.

The scheme provides for free treatment to be given to men over sixty-five years of age, women over sixty years of age, the physically handicapped, and expectant mothers, the physically handicapped being regarded as those persons who are suffering from a disability directly associated with the need for chiropody treatment or which prevents a person attending to his own feet. The various voluntary associations in the County, such as Old People's Welfare Committees and Darby and Joan Clubs, who were already operating a service prior to the issue of the Ministry's Circular or who were willing to introduce a service in accordance with certain conditions laid down by the County Council, form an essential part of the scheme, and approved expenditure incurred by the voluntary associations is reimbursed by the County Council. In addition, the County Council have, in certain areas where it has been possible to recruit chiropodists qualified in accordance with the National Health Service (Qualifications of Medical Auxiliaries) Regulations, 1954, established a direct service.

All applications for treatment, whether or not the service is administered by the Authority or by the voluntary associations, are submitted to the Divisional Medical Officers for approval or otherwise, the Divisional Medical Officers being responsible for the overall supervision of the scheme in their respective areas.

Treatment is given in a variety of ways, depending upon local circumstances and having regard to the fact that the service is mainly one for the aged and treatment must be available without the patient being required to travel long distances. The treatment may be given in the chiropodist's own premises on a notional session basis (an arrangement convenient both to the chiropodist and the County Council), at the premises of the voluntary association, at the Authority's own clinic premises, or, where necessary on medical grounds, in the patient's own home.

It was anticipated that, with a scheme of this nature, a number of difficulties would be encountered at the outset which would not prove easy to resolve. These fears have largely not been realised and, although there have been teething troubles, these have not been of a serious nature, with the result that, during the short time the service has been in operation, it has achieved a degree of success which it was not thought possible. This is in no small measure due to the excellent co-operation given by both the voluntary associations and the chiropodists.

By the end of the year there were 95 voluntary associations taking part in the scheme and, in addition, a direct service had been established in 14 health divisions. In the latter connection, the service was available at some 60 clinics and at the premises of 22 chiropodists taking part in the arrangements.

In total, 19,918 patients received treatment (19,444 aged, 421 physically handicapped and 53 expectant mothers), the total number of treatments given being 69,439.

The figure of 19,444 patients in the aged category represents some 9 per cent. of the estimated total population of men over sixty-five years of age and women over sixty. At the outset, taking the findings of the National Corporation for the Care of Old People as a guide and judging from the experience of some of the larger voluntary organisations in the County who had been operating a service for some years, it was thought that the scheme would eventually need to provide for treatment for some 15 to 20 per cent. of the aged. That, after some ten months' operation, a figure of 9 per cent. has been reached is no small achievement; indeed, in two areas—namely, the Skipton and Brighouse Divisions, percentages of 22 and 24 have already been reached. In 12 Divisions, the figure varies from 5 to 10 per cent., in five Divisions 11 to 15 per cent., and, in only two Divisions are less than 5 per cent. of the estimated aged population receiving treatment.

One reason for the varying success of the scheme in different parts of the County area is related to the existence of well-established voluntary schemes prior to 1960. Where such a scheme was in being and widely known, it has been a comparatively simple matter to expand. Another reason for the varying pattern is, of course, the shortage of chiropodists in some areas.

A service is now available in the whole of the County except for a few areas where there is an absence of a suitable voluntary association willing to operate a service, or an inability to recruit suitably-qualified chiropodists to introduce a direct service.

The need or otherwise to provide domiciliary treatment on medical grounds has received the close attention of the Divisional Medical Officers, as this method of treatment is much more costly than treatment at a centre or chiropodist's premises. Here again, the pattern varies over the County area as a whole. In three Divisions, the percentage of patients receiving domiciliary treatment during the year was from 10 to 15, in six Divisions from 16 to 20 per

cent., in five Divisions 21 to 25 per cent., and in eight Divisions more than 25 per cent., the highest figure in any Division being 33 per cent. In only one Division was the figure less than 10 per cent. It is only to be expected that variations will occur from one area or another according to the differing assessments made by general practitioners and the County Council's own medical officers and nursing staff. At the same time, any proportion over 20 per cent. must be regarded with reserve as the natural assumption would be that, if the experience gained in the chiropody service is any guide, then something like a quarter of the aged population as a whole is house-bound.

Shortly after the introduction of the service, representations were made by some chiropodists that nine treatments per session, as provided for under the scheme, is too high a figure and that, if a high standard of work is to be maintained, the number should be reduced to six. No action has been taken to recommend to the appropriate Committee that these representations merit consideration, and the reports received from the Divisional Medical Officers, with only two exceptions, suggest that a figure of nine patients per session is not unreasonable. Indeed, there are instances where chiropodists are dealing with a greater number.

There have also been representations from some chiropodists that the interval between treatments should be one month and not two months as provided for in the scheme. These representations have come largely from chiropodists employed by voluntary associations whose arrangements prior to the new scheme had provided for monthly treatment. The certificate given in each case by the Divisional Medical Officer provides for a total of six treatments in a period of twelve months, but he can authorise additional treatment if he is satisfied, after consultation with the chiropodist, that this is necessary. It is not felt, therefore, that the scheme requires any amendment in this respect. It is not accepted that every patient attending for treatment requires such treatment at regular monthly intervals.

During the year, the National Corporation for the Care of Old People published a report on a three-year survey of chiropody schemes which they had subsidised, and it is both interesting and encouraging to note how closely their findings compare with the principal features of the County scheme, both as regards the frequency of treatment and the number of patients constituting a session.

The year 1960 has also seen the introduction of the Professions Supplementary to Medicine Act, which will provide for a National Register of Chiropodists. This legislation is to be welcomed as it is only by the compiling of such a register that the present confusion regarding the training, competence and qualifications of chiropodists can be removed.

The following is a statistical summary showing the extent to which chiropody treatment has been given during the year under the agencies of the voluntary associations and directly by the County Council.

	<i>Voluntary Association Schemes</i>	<i>Direct Service by County Council</i>	<i>Total</i>
Number of sessions held:			
Notional	1,923	819	2,742
In voluntary association premises ...	1,865	—	1,865
In clinic premises	—	1,770	1,770
	<u>3,788</u>	<u>2,589</u>	<u>6,377</u>

Number of patients treated:			
Notional sessions:			
Pensioners	4,862	1,888	6,750
Physically handicapped	39	44	83
Expectant mothers	11	9	20
In voluntary association or clinic premises:			
Pensioners	4,623	3,986	8,609
Physically handicapped	39	57	96
Expectant mothers	11	21	32
Domiciliary:			
Pensioners	2,377	1,708	4,085
Physically handicapped	100	142	242
Expectant mothers	—	1	1
Total number of patients treated ...	<u>12,062</u>	<u>7,856</u>	<u>19,918</u>

Total number of treatments given:			
Pensioners	40,773	27,192	67,965
Physically handicapped	519	863	1,382
Expectant mothers	31	61	92
	<u>41,323</u>	<u>28,116</u>	<u>69,439</u>

Number of patients treated per session:			
Notional	8.9	8.7	8.8
In voluntary association or clinic premises	8.7	8.1	8.4
Percentage of total patients treated receiving domiciliary treatment	20.5	23.6	21.7
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)	5.2	3.3	8.6

Laundry Service for Incontinent Patients:

It has long been appreciated that the laundering of bed linen for incontinent patients being nursed at home presents a very real problem, not only to the members of the patient's household but also to the home nurse dealing with the cases. The severe cases of incontinence are not thought to be numerous and are normally those patients waiting for admission to hospital or being nursed at home in the terminal stages of illness.

A survey of the problem was made in the divisional areas towards the end of 1959, and the results appeared to confirm that, although the number of cases of severe incontinence was not numerous, the provision of a laundry service would meet a real need. The County Welfare Officer was consulted and offered to make available a service for dealing with foul laundry at certain of the Part III establishments in the County, and one or two hospitals also agreed to co-operate. A scheme was, therefore, put to the appropriate Committee in April, 1960, and approved. This provides for the supply by the County Council of quantities of bed linen, nightgowns or pyjamas, and receptacles for the collection of foul linen and distribution of clean linen.

Divisional Medical Officers were asked to submit their proposals for the establishment of a laundry service, and it had been hoped to report a reasonable degree of success in the introduction of this well-worth-while service. At the end of the year, however, only four Divisional Medical Officers had found it possible to start a service. It would appear, in many areas, that the greatest obstacle is not the lack of facilities for laundering the linen but that of transport; cases requiring the service may be widely dispersed and to hire transport to collect laundry, deliver it to the hospital or Part III establishment to be dealt with, and deliver clean laundry to patients, would be most difficult and quite uneconomic.

Since the scheme was first considered, disposable pads specially designed for incontinent patients have appeared on the market, and, while their use can only be considered as a second best to the provision of a laundry service, this may be the only practical solution in many areas of the County. A trial scheme using disposable pads is proceeding in three divisions and, if the results are satisfactory, the Health Committee will be asked to approve their supply generally.

DOMESTIC HELP

The year commenced with an establishment of 900 equivalent whole-time domestic helps within an overall establishment of 1,000 approved earlier by the County Council. The demand for the service has continued, and it became necessary for the Health Committee to give approval for the employment of 950 equivalent whole-time domestic helps from the 1st July, 1960. By November, the demand was still increasing and some thought was given to the impending reduction in the working week from 44 to 42 hours from the 1st January, 1961, which would mean that, from that date, the number of hours available from 950 domestic helps at 42 hours would be little more than that from 900 at 44 hours. Approval was, therefore, given to the establishment being increased to 1,000 to maintain the service at its existing level.

The expansion which has taken place in the service has been mainly in those areas where the service has been maintained at a high level and where there is no difficulty in recruiting domestic helps.

Over the year as a whole, the equivalent of 914·7 whole-time domestic helps was employed compared with 807·7 for 1959 and 777·1 for 1958. Thirteen thousand six hundred and seventy-five cases received 2,092,792 hours' help through the service, an increase of 1,252 cases and 244,753 hours when compared with 12,423 cases and 1,848,039 hours in 1959. The help provided for the aged and chronic sick represented 75·5 per cent. of cases (1959—74·7 per cent.) and 83·2 per cent. of the total hours (1959—82·3 per cent.).

<i>Classification of Cases Assisted</i>						<i>No. of Cases</i>	<i>Hours employed</i>
Maternity	...	...	...	...	...	1,269	80,793
Tuberculosis	...	...	...	...	...	97	18,954
Chronic Sick (a) aged 65 or over				...	...	10,324	1,740,904
(b) under 65			...	...	...	1,133	166,528
Other	...	...	...	...	...	852	85,613
Totals						13,675	2,092,792

MENTAL HEALTH

The year 1960 has earned a place of honour in the archives of British public health history. On November 1st the 1959 Mental Health Act came into effect bringing to local health authorities vast new responsibilities, the full extent of which cannot yet be realised or even charted.

The major purpose of earlier legislation was to ensure the segregation from the community of the seriously ill and subnormal mental patients. This "custodial" approach is now replaced by "community care," a change of emphasis which gives priority for the growth of services designed to enable patients to lead as normal a life as possible within the community, to rehabilitate the mentally handicapped and to offer care, guidance and social support to patients receiving treatment, whether in hospital or at home.

To meet this challenge plans were formulated in 1959 and details of the proposed scheme for a comprehensive mental health service were described in my last Annual Report. The proposals subsequently received the assent of the Minister of Health paving the way for a year of more intensive preparation and planning in 1960.

The main features of the scheme are summarised below, with a description under each heading of the stage of development reached to date:—

The Appointment of Mental Welfare Officers:

An establishment of 53 mental welfare officers is provided. Seven of this number are senior officers (salary on the APT III scale) appointed to the seven "mental health areas" into which the county area is divided, each mental health area representing the catchment area of one of the larger mental hospitals. The senior mental welfare officers provide the personal link between these hospitals, the divisional medical officers and the "field" mental welfare officers. It is also their duty to advise and guide their junior colleagues. The latter are centred on the divisional health offices and are under the administrative control of the divisional medical officers.

Details of the Mental Health Areas are as follows:—

- (1) *Clifton*—comprising Harrogate B., Ripon City, Knaresborough U., Nidderdale R., Ripon and Pateley Bridge R. (Health Division No. 7).
Population: 102,000.
Staff: 1 Senior Mental Welfare Officer.
3 Mental Welfare Officers.
- (2) *Menston*—comprising Keighley B., Pudsey B., Aireborough U., Baildon U., Barnoldswick U., Bingley U., Denholme U., Earby U., Horsforth U., Shipley U., Silsden U., Skipton U., Skipton R.
[Health Divisions Nos. 1 (part), 3, 4, and 5 (part)].
Population: 257,000.
Staff: 1 Senior Mental Welfare Officer.
8 Mental Welfare Officers.

- (3) *Middlewood*—comprising Adwick le Street U., Bentley with Arksey U., Conisbrough U., Dearne U., Maltby U., Mexborough U., Penistone U., Rawmarsh U., Swinton U., Tickhill U., Doncaster R., Kiveton Park R., Rotherham R., Thorne R., Wortley R.
[Health Division Nos. 22 (part), 26 (part), 27, 29, 31].
Population: 384,000.
Staff: 1 Senior Mental Welfare Officer.
9 Mental Welfare Officers.
- (4) *Naburn—Bootham Park—De La Pole*—comprising Goole B., Selby U., Goole R., Selby R., Tadcaster R., Wetherby R.
(Health Divisions Nos. 9 and 10.)
Population: 96,000.
Staff: 1 Senior Mental Welfare Officer.
3 Mental Welfare Officers.
- (5) *Scalebor Park—Lancaster Moor*—comprising Ilkley U., Otley U., Wharfedale R. (for Scalebor Park Hospital), and Bowland R., Sedbergh R. and Settle R. (for Lancaster Moor Hospital).
[Health Divisions Nos. 1 (part) and 5 (part)].
Population: 58,500.
Staff: 1 Senior Mental Welfare Officer.
2 Mental Welfare Officers.
- (6) *Stanley Royd*—comprising Castleford B., Morley B., Pontefract B., Ossett B., Featherstone U., Garforth U., Hemsworth U., Horbury U., Knottingley U., Normanton U., Rothwell U., Stanley U., Hemsworth R., Osgoldcross R., Wakefield R.
(Health Divisions Nos. 11, 12, 13, 16 and 23.)
Population: 328,500.
Staff: 1 Senior Mental Welfare Officer.
9 Mental Welfare Officers.
- (7) *Storthes Hall*—comprising Batley B., Brighouse B., Spenborough B., Todmorden B., Colne Valley U., Cudworth U., Darfield U., Darton U., Denby Dale U., Dodworth U., Elland U., Hebden Royd U., Heckmondwike U., Holmfirth U., Hoyland Nether U., Kirkburton U., Meltham U., Mirfield U., Queensbury and Shelf U., Ripponden U., Royston U., Saddleworth U., Sowerby Bridge U., Stocksbridge U., Wath upon Dearne U., Wombwell U., Worsbrough U., Hepton R., Penistone R.
[Health Divisions Nos. 15, 17, 18, 19, 20, 22 (part), 25 and 26 (part)].
Population: 425,000.
Staff: 1 Senior Mental Welfare Officer.
11 Mental Welfare Officers.

The seven senior mental welfare officers were recruited in the autumn of 1960. Although none possesses a psychiatric social worker qualification they are nevertheless able and well experienced and have commenced their duties with energy and enthusiasm.

The recruitment of the other mental welfare officers proved to be more difficult and protracted due to the absence of any recognised qualification and the paucity of candidates with adequate experience and/or educational background. The introduction of a much improved salary scale fortunately eased the situation and the establishment was almost filled by the end of the financial year. Former mental health social workers and duly authorised officers constitute the experienced nucleus supplemented by some officers with experience of mental nursing or social work and a handful of inexperienced trainees.

During the difficult early stages experienced officers on the staff of the County Welfare Officer provided some welcome and greatly appreciated assistance, especially for emergencies.

The problem of training the less experienced mental welfare officers (including those lacking the dual experience with subnormality *and* illness) had, in the absence of any national scheme, to depend upon in-service training under the wing of the senior mental welfare officers supplemented by attendance at the National Association for Mental Health Induction and Refresher Courses.

The establishment provided for the appointment of a Psychiatric Social Worker-Tutor but no suitable candidates came forward during 1960. In order to make this post more attractive it has now been agreed to make an appointment jointly with the National Association for Mental Health, the tutor appointed being available for National Association for Mental Health educational work for a total of four months per annum.

The medical staff at some of the hospitals have provided some informal but invaluable training at case-conferences and other meetings and, at two of the hospitals, mental welfare officers have attended the mental nursing lectures.

Liaison with Hospitals and General Practitioners:

Community care cannot be successful without the closest possible co-operation with the general practitioners and psychiatrists. In the first days and weeks of the new service a series of meetings with consultant staff were held at all the larger mental hospitals. The County scheme was explained to the consultants and methods of co-operation were discussed. The senior mental welfare officers were introduced and their functions explained. As a result of these meetings it has been possible to arrange:—

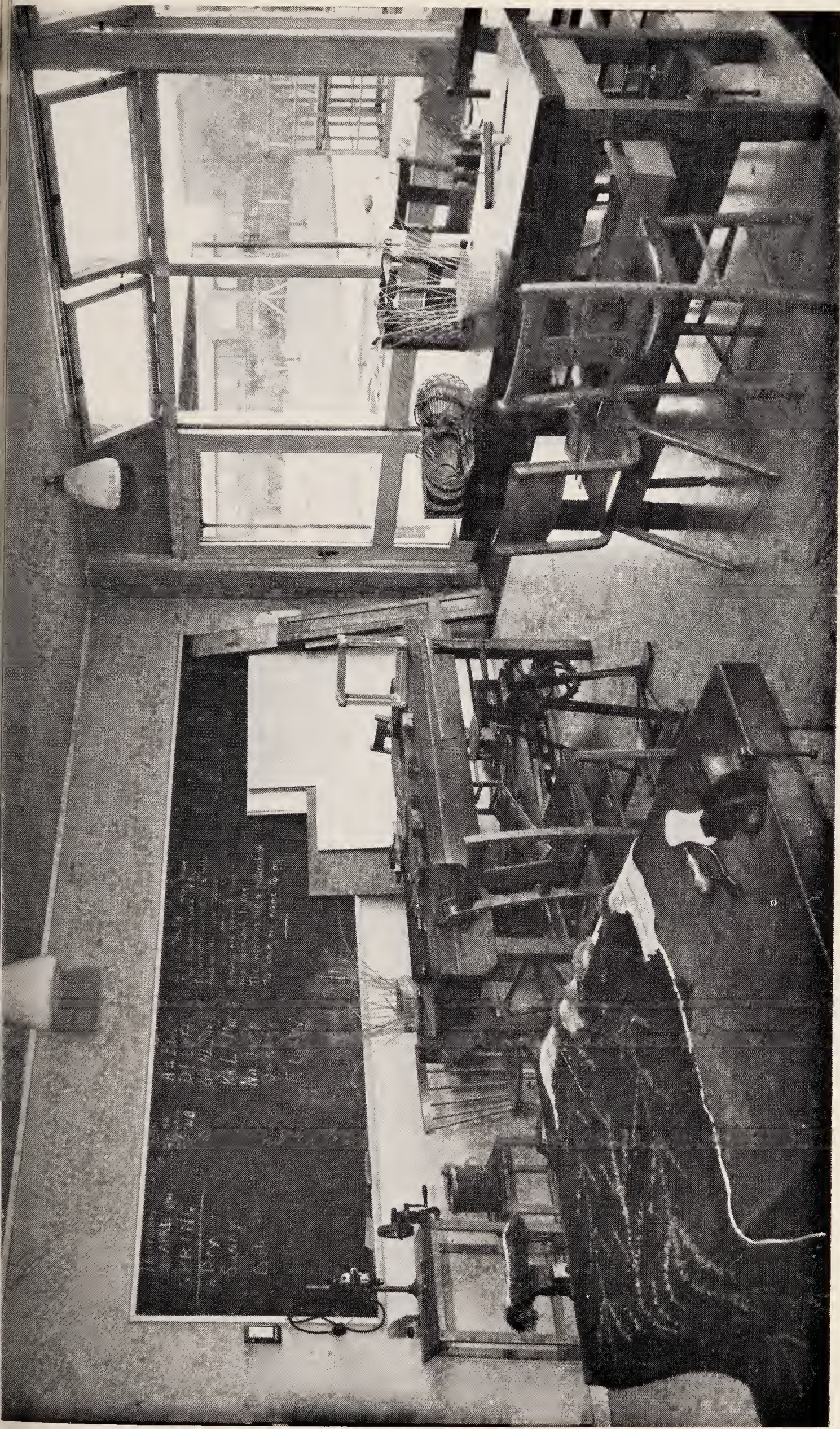
- (1) Attendance of mental welfare officers at case conferences, out-patient clinics, hospital meetings etc.
- (2) The availability of mental welfare officers for pre- and after-care visits requested by the consultants as well as for the arrangement of admissions (both informal and compulsory).
- (3) Co-ordination of work with the hospital social workers.
- (4) The easy exchange of information between psychiatrists, divisional medical officers and general practitioners.



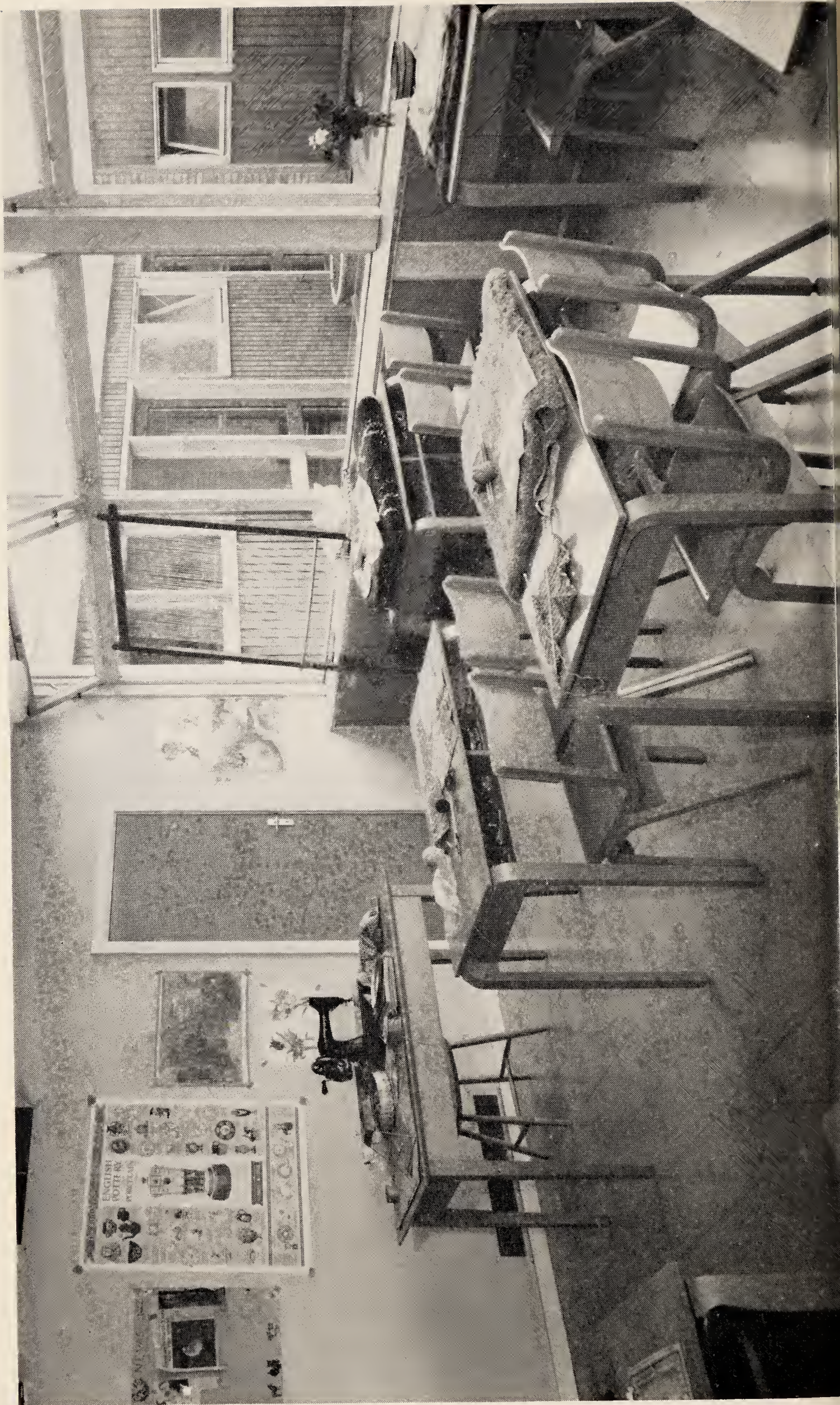
Airedale Training Centre



A child's first day at the Training Centre



Airedale Training Centre—adult work room



General practitioners have been kept fully informed of the changes in legislation and procedure and also of each stage of development of the County Council's new service. In particular, the wider scope of the duties of mental welfare officers as compared with their predecessors, the duly authorised officers, has been stressed. It has been explained that the new officers have far more to offer than simply removal of the patient; they constitute an invaluable link between the patient and the entire gamut of social services. The latter includes local authority services such as housing, home nursing, health visiting, home helps, police and probation services etc. as well as such organisations as the National Assistance Board, Employment Exchanges, National Insurance and Pensions, and a number of voluntary organisations. Furthermore the attention of the general practitioners has been drawn to the role of the more experienced mental welfare officers, e.g. as professional case-workers operating under the guidance of psychiatrists and general practitioners to ensure continuity of advice and treatment.

Aspects of the new service requiring more detailed discussion with the representatives of the general practitioners were submitted for consideration by the Standing Sub-Committee on Co-operation, an entirely medical committee comprising the County Medical Officer, senior members of his staff and several members of the West Riding Medical Committee. This procedure undoubtedly obviated some of the difficulties and misunderstandings to which a new service is prone.

Training Centres for the Subnormal:

The expansion of training facilities was established policy even before the inception of the Mental Health Act but there can be no doubt that the Act reinforced the sense of urgency and accelerated the rapidity of development. Some idea of the progress made up to and including 1960 may be gathered from the following figures:—

Period	Number of new places provided		
	Junior	Adult	TOTAL
to 1956	90	30	120
1956-58	226	83	309
1958-60	132	88	220
TOTALS as at 31.12.60	448	201	649

Future building projects, several of which are already well-advanced, will more than double the present provision within, it is hoped, the next two or three years. We shall then have places for over 1,400 trainees, including 800 adults. This target represents 1 per 1,200 of the population and is a reasonable estimate, by existing standards, of our total need. It is impossible however to make an accurate forecast of our future needs. There are many imponderable factors not least of which is the extent to which adult training techniques will develop along vocational or industrial lines. Hitherto we have concentrated on social training, that is, we have endeavoured to train the subnormal patient to look after himself and his affairs so that he may become less dependent on others

and at the same time more acceptable to normal society. This training includes specific practical instruction in such matters as the handling of money, caring for property, recognition of notices, simple household management, the acquisition of desirable social habits and attitudes etc. One of the final stages of this process of social integration would be gainful employment within the community but experience has taught us that only a small minority of our trainees seem capable of reaching this goal. Would we achieve more by neglecting some of the basic social training in favour of industrial training in "workshop" facilities or "sheltered" employment provided in our centres? Would the introduction of such facilities be practicable when limited to only a minority of those in attendance? Should this aspect of training be solely the responsibility of the Ministry of Labour in their industrial rehabilitation units? These are but a few of the questions the answers to which will be found only in the light of experience. It is necessary to tread warily but not too timidly and we have so designed our newer centres as to allow for expansion and some measure of modification if and when the need arises.

The following is a list of the training centres in full operation at the end of 1960:—

Centre	No. of Places	Staff		
		Supervisors	Assistant Supervisors or Nursery Assistants	Male Instructors
Adwick le Street ..	76	1	4	1
Airedale (Castleford) ..	76	1	4	1
Brighouse	27	1	2	—
Ecclesfield	76	1	4	1
Heckmondwike ..	68	1	4	1
Hemsworth	43	1	3	1
Horsforth	27	1	2	—
Keighley	50	1	3 + 1 part-time	1
Maltby	76	1	4	1
Ossett	27	1	2	—
Wath upon Dearne ..	76	1	4	1
Wombwell	27	1	2	—

Details of new centres, planned or in course of construction, are as follows:—

1959-60 Capital Building Programme.

Harrogate 76 places.

Horsforth 76 places.

Rawcliffe 60 places (see plan on page 138).

1960-61 Capital Building Programme.

West Ardsley	...	76 places.
Wombwell	...	Extension for 60 adults.
Adwick le Street	...	Extension for 22 adults.
Wath upon Dearne		Extension for 22 adults.

Future Capital Projects.

Airedale (Castleford)		Extension for 32 adults and 4 " special care " patients.
Brighouse	...	New centre for 76 places.
Ecclesfield	...	Extension for 22 adults.
Hemsworth	...	Extension for 40 adults.
Keighley	...	Extension for 40 adults.
Kirkburton	...	New centre for 76 places.
Maltby	...	Extension for 44 adults and 4 " special care " patients.
Rothwell	...	New centre for fifty places.
Skipton	...	New centre for 40 places.

TRAINING OF STAFF:

It has been the practice of the Authority to second two members of the training staff each year to the Diploma Course of the National Association for Mental Health. In view of the rapid growth of the service the Mental Health Sub-Committee has approved in principle to the attendance of 10 teachers per annum, commencing with the year 1961-2.

As part of the in-service training two refresher courses for training centre staff were held at the W.R.C.C. Adult College at Grantley Hall during 1960. Also visits to the workshops at Meanwood Park and Rampton Hospitals were arranged for the male instructors and a two-day course was held at the Leckmondwike Training Centre.

HOME TRAINING:

A staff of 12 Home Teachers provide training for subnormal patients who are either unfit for attendance at a training centre or reside in areas not yet provided with centre facilities. Where practicable the patients are trained in groups. Three of these group training classes, namely those at Kirkburton, Snaith and Harrogate, have grown to the extent of coping with over 30 patients each in premises much below the standard of existing training centres. Smaller groups have attended at Skipton, Settle, Benthams, Tadcaster, Royston, Wombwell, Worsbrough Bridge and Darton. Most—and possibly all—of the group training classes will cease to be required when the training centre building programme is completed.

Hostel Accommodation:

Reference was made in my last Annual Report to the need for an experimental approach to this problem. This cautious policy appears to be fully justified by the diversity of expert opinions on the respective responsibilities of hospitals and local health authorities, and also by the chastening experience of those authorities who have found it easier to provide a hostel than to fill it. It is nevertheless clear that hostel accommodation, even if on a restricted scale, is certainly required for subnormal patients of all ages and that some small provision will have to be made for post-psychotic patients. It is equally apparent that the demand for Part III accommodation for the elderly and reasonably stable subnormal is likely to increase steadily over the years.

The Authority has now agreed in principle to the establishment of a residential hostel for 25 mentally subnormal adults and a separate hostel for approximately 20 post-psychotic patients requiring social rehabilitation and support after hospital treatment. It is probable that both hostels will be erected on sites adjacent to that of the new training centre at West Ardsley in the Borough of Morley and will therefore be within easy reach of potential sources of employment at Leeds, Morley, Wakefield, Dewsbury, Batley and Ossett. The facilities of the training centre will of course also be available for patients who are temporarily unemployed or are receiving short-stay care.

The next step should be the provision of a small hostel for subnormal children primarily to meet the needs of children in the more remote rural areas who would not otherwise be able to attend a training centre. It is anticipated that the hostel would normally only be used for 5 days per week, the children spending the week-ends at home and so maintaining the all-important links with parents, brothers and sisters.

Statistics:

MENTALLY ILL PATIENTS:

Lunacy and Mental Treatment Acts

Action taken during the period 1.1.60 to 31.10.60.

(1959 Statistics in parentheses.)

Lunacy Act, 1890, patients admitted under Section 16, 158(280); under Section 20, 281(361); under Section 21, 6(20); under Section 11, 30(27).

Mental Treatment Act, 1930, assistance given in respect of patients admitted under Section 1, 75(301); under Section 5, None(1).

191 patients were admitted to hospitals informally [certain parts of Section 315 of the Lunacy Act, 1890, having been repealed by the Mental Health Act, 1959 (Commencement No. 1) Order 1959 on the 6th October, 1959].

One patient was dealt with under Section 30 of the Magistrates' Courts Act, 1952 and the duly authorised officers were approached by general medical practitioners or relatives in 218 instances (264) where action was considered unnecessary.

Mental Health Act, 1959

Action taken during the period 1.11.60 to 31.12.60.

Admissions arranged by Mental Welfare Officers.

Compulsory admissions to hospital

Section 25, Mental Health Act, 1959	—	43
Section 26, do.	—	20
Section 29, do.	—	75
Informal admissions	—	80

Attendances of Mental Welfare Officers at Hospital Out-Patient Clinics

The Hospital Management Committees throughout the Riding have continued and extended the provision of out-patient clinics at General Hospitals and other premises and there are now 22 such clinics. At many of them both West Riding and County Borough patients attend. 21 Mental Welfare Officers attend these clinics to assist the Consultants and it is clear that a further extension of this service will be required. During the year 165 new cases were referred as being in need of care and after-care and at the end of the year 554 patients were receiving home visits.

MENTALLY SUBNORMAL PATIENTS
Mental Deficiency Acts 1913-38

					Under age 16		Aged 16 and over	
Particulars of cases reported during the period					M.	F.	M.	F.
1.1.60 to 31.10.60								
(a) Cases ascertained to be defectives "subject to be dealt with":—								
Number in which action taken on reports by:—								
(1) Local Education Authorities on children:								
(i) While at school or liable to attend school					51	60	—	—
(ii) On leaving special schools					8	6	11	7
(iii) On leaving ordinary schools					17	17	—	—
(2) Police or by Courts					—	—	—	—
(3) Other Sources					10	6	10	8
					—	—	—	—
Total of (a)					86	89	21	15
					==	==	==	==
(b) Cases reported who were found to be defectives but were not regarded as "subject to be dealt with" on any ground					—	—	6	8
(c) Cases reported who were not regarded as defectives and are thus excluded from (a) or (b)					—	1	3	2
(d) Cases reported in which action was incomplete at 31st October, 1960, and are thus excluded from (a) or (b)					13	9	2	2
					—	—	—	—
Total of (a)-(d) inclusive ...					99	99	32	27
					==	==	==	==
Disposal of cases reported during the period								
1.1.60 to 31.10.60								
(a)								
(i) Placed under Statutory Supervision ...					83	86	19	14
(ii) Placed under Guardianship					—	—	—	—
(iii) Taken to "Places of Safety"					—	—	—	—
(iv) Admitted to Hospitals					3	3	2	1
					—	—	—	—
Total of (a) ...					86	89	21	15
					==	==	==	==
(b) Of the cases not ascertained to be defectives "subject to be dealt with"								
(i) Placed under Voluntary Supervision ...					—	—	5	6
(ii) Action unnecessary					—	—	1	2
					—	—	—	—
Total of (b) ...					—	—	6	8
					==	==	==	==
(c) Cases reported at 1(a) or (b) above who removed from the area or died before disposal was arranged					—	—	—	—
					—	—	—	—
Total of (a)-(c) inclusive ...					86	89	27	23
					==	==	==	==

The reports under Section 57(3) of the Education Act, 1944 have been withdrawn during the year in respect of 4 boys and 1 girl.

Mental Health Act, 1959

Report covering period 1.11.1960 to 31.12.1960.

Mentally subnormal patients.

Particulars of cases referred.

						Under age 16		Aged 16 and over	
						M.	F.	M.	F.
Number of cases in which [a decision has been recorded by the Education Committee that a child has a disability of mind which makes him unsuitable for education at school						5	6	—	—
Other Sources						1	1	3	—

Care recommended in respect of these cases.

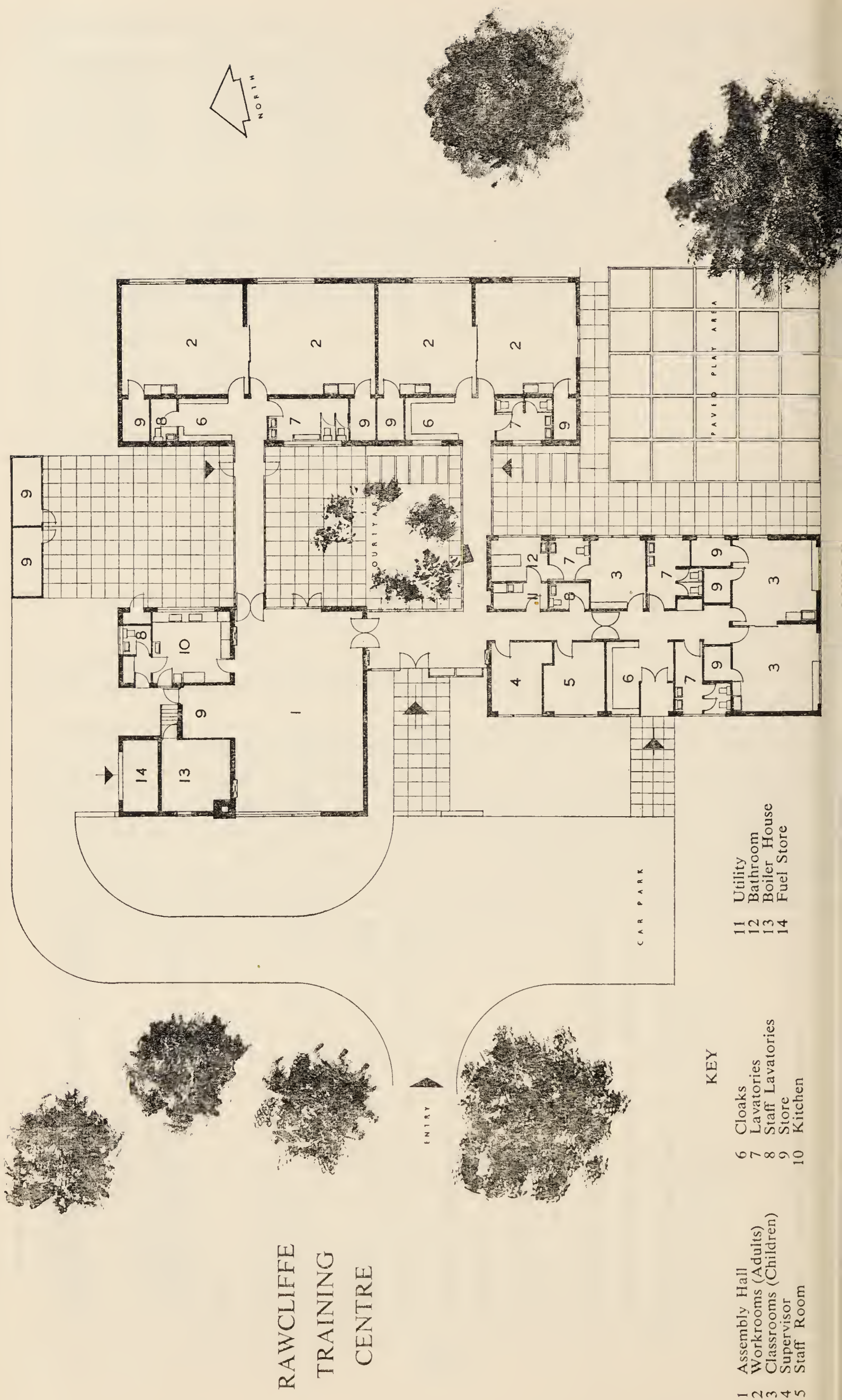
Hospital care						2	2	1	—
Attendance at a Training Centre						4	5	—	—
Care or Guidance						—	—	2	—

In the cases of 13 school leavers (8 males and 5 females) the Local Education Authority passed on information that they might require care or guidance.

During the year 86 patients were admitted to hospitals, as follows: placed under Section 3 of the Mental Deficiency Act, 1913, 1; by Orders made by Courts, 10; and 75 by informal admission; 205 patients were placed under Statutory Supervision and 80 patients were removed from the Statutory Supervision list; the number of patients under guardianship at the end of the year was 12. 771 (491 males and 280 females) subnormal and severely subnormal patients in community care were in full-time employment and 422 (155 males and 266 females) were assisting parents and relatives at home and were considered to be adequately occupied and employed. For the number of patients under Local Health Authority care at 31.12.60, see table appended:—

	Mentally ill				Psychopathic				Mentally ill				Psychopathic				Mentally ill				Psychopathic			
	Under age 16		16 and over		Under age 16		1 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Number of Patients under L.H.A. care at 31.12.60	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)				
Receiving training or occupation in day centre ...	—	—	1	1	1	—	—	—	157	145	106	117	124	104	61	83	282	249	168	201				
Awaiting training or occupation in day centre ...	—	—	—	—	—	—	—	—	5	11	31	22	7	2	8	9	12	13	39	31				
Receiving training or occupation in residential centre	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—				
Awaiting training or occupation in residential centre...	—	—	—	—	—	—	—	—	2	1	1	1	—	—	—	—	2	1	1	1				
Receiving home training ...	—	—	2	3	—	—	—	—	1	4	2	17	—	—	3	10	1	4	7	30				
Awaiting home training ...	—	—	1	4	—	—	—	—	2	2	9	33	2	2	7	10	4	4	17	47				
Resident in L.A. home/hostel ...	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—				
Awaiting residence in L.A. home/hostel ...	—	—	1	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	1	—				
Resident at L.A. expense in private residential home...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—				
Resident at L.A. expense by boarding out in private home ...	—	—	—	—	—	—	—	—	—	—	1	2	—	1	1	—	—	1	2	2				
Receiving home visits and not included above ...	1	1	205	341	—	—	5	1	39	55	603	535	60	54	189	194	100	110	1002	1071				
Others (including not yet visited) ...	—	—	—	2	—	—	—	—	3	2	7	5	—	—	1	—	3	2	8	7				
Totals ...	1	1	210	351	1	—	5	1	210	219	761	731	193	162	271	306	405	382	1247	1389				
Number of patients in L.H.A. area on waiting list for admission to hospital at 31.12.60 ...	—	—	—	—	—	—	—	—	—	3	—	—	14	19	1	3	14	22	1	3				
In urgent need of hospital care ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—				
Not in urgent need of hospital care ...	—	—	3	1	—	—	—	—	1	1	1	2	10	6	3	2	11	7	7	5				
Number of Patients admitted temporarily for residential care during 1960.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—				
to N.H.S. hospitals ...	—	—	—	—	—	—	—	—	14	4	13	18	41	38	7	9	55	42	20	27				
Elsewhere ...	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—	—	1	—	—	1				

RAWCLIFFE TRAINING CENTRE



KEY

- | | | | |
|----|-----------------------|----|--------------|
| 1 | Assembly Hall | 11 | Utility |
| 2 | Workrooms (Adults) | 12 | Bathroom |
| 3 | Classrooms (Children) | 13 | Boiler House |
| 4 | Supervisor | 14 | Fuel Store |
| 5 | Staff Room | | |
| 6 | Cloaks | | |
| 7 | Lavatories | | |
| 8 | Staff Lavatories | | |
| 9 | Store | | |
| 10 | Kitchen | | |

PART V

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

Atmospheric Pollution

Swimming Baths

ENVIRONMENTAL HYGIENE

At the commencement of the year the staff of County Public Health Inspectors comprised a Chief and two Inspectors. During March Mr. R. D. Irving retired and in May Mr. F. C. Brookes followed. Mr. D. Greenwood commenced duties in August bringing up the establishment to its present allotted number, viz. a Chief Public Health Inspector and one Public Health Inspector.

Food and Drugs Act, 1955:

The coming into operation of The Milk (Special Designation) Regulations, 1960, on the 1st October, 1960, for producers' licences; and on the 1st January, 1961, for all dealers in milk will, no doubt, place very considerably increased duties upon the County Council due to dealers' licences having to be issued by the County Council as the Food and Drugs Authority concerned (excepting four County Districts who have Food and Drugs powers). Under these Regulations the County Council has issued as from the 1st January, 1961, dealers' licences as set out below:—

Number of Licence Holders	Bottling of T.T. Milk (Raw)	Pre-packed T.T. Milk (Raw)	T.T. Milk (Pasteurised)	Pasteurised Milk	Sterilised Milk
2,840	20	344	698	875	2,262

THE MILK (SPECIAL DESIGNATION) (PASTEURISED AND STERILISED MILK) REGULATIONS, 1949-53:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1960:

The pasteurised and sterilised milk producing establishments licensed by the County Council have been regularly inspected during the year to ensure that the conditions attached to the licences were being observed.

The inspections carried out by the County Public Health Inspectors were to ascertain that milk was being efficiently heat-treated, also for checking cleanliness of premises and personnel and, in general, to see that the plant and equipment were satisfactory.

Milk in relation to which the special designation "Pasteurised" is used shall be pasteurised, i.e.: (a) retained at a temperature of not less than 145°F. and not more than 150°F. for at least 30 minutes (the "Holder" system); (b) retained at a temperature of not less than 161°F. for at least 15 seconds (the "High Temperature, Short Time" system). Milk treated by either system must be immediately cooled to a temperature not exceeding 50°F.

Pasteurised milk samples are subjected to the phosphatase and methylene blue tests. The former is to test the efficiency of the treatment as to whether or not the milk has been properly pasteurised or whether any raw milk has become mixed after treatment. The methylene blue test shows the keeping quality of the treated milk.

Sterilised milk must be filtered or clarified, homogenised and heated to and maintained at such a temperature, not less than 212°F. for a period as to ensure its compliance with the prescribed turbidity test.

The table below gives details of licensees:—

PASTEURISED MILK:

- Busfield & Hargreaves, Rawson Dairy, Old Fold, Farsley, near Leeds.
- Crawshaw, J., Blake Lea Dairy, 103, Arksey Lane, Bentley, near Doncaster.
- Doncaster Co-operative Society Ltd., Dairy Department, York Road, Doncaster.
- Doxey, C., Nutwell Lane, Armthorpe, near Doncaster.
- Express Dairies (London) Ltd. (took over Dobson's Dairies Ltd., Barnoldswick, in November).
- Goole Co-operative Society Ltd., Centenary Road, Goole.
- Harrison, R. H., Manor Farm, Conisbrough, near Doncaster.
- Mawer's Dairy, Glentworth House, Skellow, near Doncaster.
- Maxfield, A. E., Ivanhoe Dairy, 37, Church Street, Conisbrough, near Doncaster.
- Exors.:—Miss B. J. Mudd, Aldborough Dairy, Boroughbridge.
- Oates, J. E. & E., Thorne Dairies, 3, North Eastern Road, Thorne, near Doncaster.
- Pontefract Industrial Co-operative Society Ltd., Dairy Department, Horsefair, Pontefract.
- Rotherham Co-operative Society Ltd., The Dairy, Progress Drive, Bramley, near Rotherham.
- Salmon, P., Ashbrooke, Littlethorpe, near Ripon.
- Stocksbridge Co-operative Society Ltd., Shay House Lane, Stocksbridge, near Sheffield.
- West Marton Dairies Ltd., West Marton, Skipton.
- Wharfedale Creamery Co. Ltd., 1, Bolton Bridge Road, Ilkley. (ceased production in May)
- Whittaker's Wholesale Dairies Ltd., 77, Tenter Balk Lane, Adwick le Street, near Doncaster.
- Wholesale Dairies (Rotherham and District) Ltd., Meadow Works, Rawmarsh, near Rotherham.
- Windhill Co-operative Society Ltd., The Dairy, Thomas Place, Shipley.

STERILISED MILK:

- Wholesale Dairies (Rotherham and District) Ltd., Meadow Works, Rawmarsh, near Rotherham.

Details of samples, with results of examinations, are as follows:—

	Tuberculin Tested (Pasteurised)				Pasteurised				Sterilised	
	Phosphatase Test		Methylene Blue Test		Phosphatase Test		Methylene Blue Test		Satis- factory	Unsatis- factory
	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.		
Obtained by the County Public Health Inspectors from producers licensed by the County Council	79	—	79	—	285	1	285	1	19	—

The Ministry of Agriculture, Fisheries and Food, Milk Products Division, was supplied with details of all samples obtained by the Departmental staff, as also were the Medical Officers of Health for the County Districts concerned.

I should again like to thank Dr. Little, Director of the Public Health Laboratory, Wakefield, for his assistance in dealing with samples of milk submitted also Dr. Smith, Director of the Public Health Laboratory, Bradford, for supplying copies of reports on 49 samples of pasteurised milk from dealers who obtain their supplies from establishments licensed by the County Council. All these samples were satisfactory.

SPECIFIED AREAS FOR THE SALE OF MILK:

The whole of the Administrative County is now covered by Specified Areas and only designated milk, i.e. pasteurised, sterilised and tuberculin tested may legally be sold by retail for human consumption. This must be regarded as an important public health measure.

The duties involved in essential surveys during the past years have been carried out by the County Public Health Inspectors who have been ably assisted by the Inspectors of the County Districts, to whom I express my thanks for their kind co-operation.

It is very satisfactory to note that the country in general is now supplied with designated milk for human consumption. This, together with the elimination of bovine tubercle in herds, should reduce the incidence of non-respiratory tuberculosis to almost insignificant levels.

SAMPLING OF HEAT-TREATED MILKS IN THE COUNTY DISTRICTS:—

Tuberculin Tested		Pasteurised		Sterilised	
Number obtained	Percentage satisfactory	Number obtained	Percentage satisfactory	Number obtained	Percentage satisfactory
690	98.3	645	99.5	264	100.0

BACTERIOLOGICAL EXAMINATION OF RAW MILKS IN THE COUNTY DISTRICTS:—

	Tubercle		B. abortus	
	Number examined	Number positive	Number examined	Number positive
Tuberculin Tested ..	426	2	441	85
Ordinary	189	4	22	3

SUPPLY OF MILK TO SCHOOL CHILDREN:

THE PROVISION OF MILK AND MEALS AMENDING REGULATIONS, 1959:

These Regulations prescribe:—

“ On every day on which a school maintained by an authority is open for instruction, except Saturday and Sunday, the authority shall provide milk to drink in such quantities as may reasonably be expected to be required to enable day pupils attending the school on that day, and wishing to take it regularly, to have one-third of a pint each, except that in a special school two-thirds of a pint may be provided for a delicate pupil.

The sources and quality of the milk (which shall as far as possible be pasteurised, or failing that tuberculin tested) shall be approved by the Medical Officer for the County, after consultation with the Medical Officer of Health for any County District concerned.”

Pasteurised milk is the main source of supply in the County, although a small quantity of tuberculin tested milk is supplied where there have been difficulties in obtaining pasteurised.

Details of samples obtained during the year are as set out:—

		Number	Satisfactory	Unsatisfactory
Pasteurised .. ..	...	126	126	—
Tuberculin Tested ..	...	21	19	2

Biological examinations were made of the tuberculin tested milk samples and all were tubercle free.

A positive result in the examination for B. abortus was reported in the case of one sample, action being taken in this instance.

SAMPLING OF MILK AT HOSPITAL FARMS:

During the year there were two farms—Stanley Royd, Wakefield, and Stansfield View, Todmorden—at which samples were obtained on behalf of the Ministry of Health.

Details of the reports made are given below:—

Hospital	Methylene Blue Test		Biological Examination	
	Number Obtained	Number Satisfactory	Tubercle	Brucella Abortus
Stanley Royd	10	10	3 Samples All Negative	29. 4.60—Ring test ++ 10. 8.60 do. + 7.11.60 do. ++
Stansfield View	9	9	3 Samples All Negative	3 Samples. All Negative.

Reports regarding the Brucella reports were forwarded to the Ministry of Agriculture, Fisheries and Food (Animal Health Division) and copies of all reports supplied to the Ministry of Health, Leeds Regional Hospital Board, the appropriate Hospital Management Committees and the Medical Officers of Health concerned.

The work involved in carrying out the above duties have, from time to time, been recognised by the Ministry who, in a communication in December, 1960, stated “We should like to take this opportunity of thanking you for your co-operation and help in this matter of sampling milk from hospital dairy farms.”

FOOD HYGIENE REGULATIONS, 1955, AND ICE-CREAM:

The number of Registered Premises under the above Regulations together with details of samples obtained are given below:—

	Catering Establishments	Bake-houses	Other Food Shops	Number of Food Premises registered under Section 16, Food and Drugs Act, 1955		
				Manufacturers of Ice-Cream	Retailers of Ice-Cream	Sausages, Potted or Preserved Foods
Municipal Boroughs and Urban Districts...	1,718	670	10,282	78	4,381	1,288
Rural Districts ...	888	130	2,477	12	1,272	291

	Sampling							
	Bacteriological Examinations							
	Ice-Cream		Ice-Lollies		Imitation Cream		Other Foods	
	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.
Municipal Boroughs and Urban Districts ...	1,046	39	111	3	28	9	337	77
Rural Districts ...	562	19	—	—	—	—	60	1

MEAT INSPECTION:

Total number of slaughterhouses in the 89 County Districts—257.

Details regarding the inspection of meat are as given in the following table:—

	Cattle ex-cluding Cows	Cows	Calves	Sheep and Lambs	Pigs	Horses
Number killed	60,731	14,653	3,206	226,742	258,129	2,123
Number inspected	60,702	14,609	3,204	226,688	258,111	2,123
All diseases except Tuberculosis and Cysticerci:						
Whole carcasses condemned ...	67	92	89	300	637	20
Carcasses of which some part or organ was condemned ...	10,648	3,494	56	5,295	24,707	333
Percentage of the number inspected affected with disease other than tuberculosis and cysticerci	17·7	24·5	4·5	2·4	9·8	16·6
Tuberculosis only:						
Whole carcasses condemned ...	17	23	—	—	17	1
Carcasses of which some part or organ was condemned ...	674	468	3	4	6,315	—
Percentage of the number inspected affected with tuberculosis	1·1	3·4	0·1	0·0	2·5	0·0
Cysticercosis:						
Carcasses of which some part or organ was condemned ...	233	32	—	—	—	—
Carcasses submitted to treatment by refrigeration	109	11	—	—	—	—
Generalised and totally condemned	—	—	—	—	—	—

REPORT OF ANALYST:

All County Inspectors of Weights and Measures are also appointed Sampling Officers for the purpose of the Food and Drugs Act, and the work of sampling is carried out under the control of the Chief Inspector of Weights and Measures. Details of the work carried out under the Act are referred to in the Annual Report to the County Council of the Public Analyst, who has kindly consented to its inclusion in this Report:—

“During the year, 3,027 samples were submitted by your Inspectors under the Food and Drugs Act, 1955, as set out under the following categories:—

	<i>Total Samples</i>	<i>Adulterated or Below Standard</i>	<i>Percentage Adulterated or Below Standard</i>
Milk	1,639	45	2·7
Milk ‘Appeal to Cow’ ...	18	—	—
Milk, Channel Islands ...	201	11	5·5
Milk, Hot	1	—	—
Foods and Drugs	1,168	65	5·5
All Samples	3,027	121	4·0

As in 1959, most of the samples were taken ‘informally’; in such cases the Inspectors sent the package complete with labels for our examination. As a result, several irregularities and contraventions of the Labelling of Food Order were reported.

Notes on Adulterated or Irregular Samples.

The proportions of irregular and substandard samples compare satisfactorily with those found by other Authorities.

Milk. 1,639 samples of ordinary and sterilised milk were analysed. 45 samples were adulterated or below standard: 25 were deficient in fat, 17 contained added water and 3 were deficient in fat as well as being watered. The worst example contained over 25 per cent. of added water.

Channel Islands Milk must contain at least 4 per cent. of fat; 201 samples were analysed, 11 were below standard, the lowest fat content being only 2·75 per cent.

Potted Meat. In the absence of a legal standard, we have expected Potted Meat to consist essentially of meat and to be free from starchy filler. Out of 43 samples tested, 13 were reported as being low in meat and 3 contained starch and so should have been sold as meat paste.

Potted Beef. 9 samples were analysed; one was low in meat content.

Sausages. No legal standards have been laid down as yet, but Public Analysts continue to expect Pork Sausage to contain at least 65 per cent. of meat, and Beef Sausage to contain at least 50 per cent. of meat. In our experience the majority of samples are well above these limits.

Pork Sausages. 35 samples were submitted; 7 samples were found to contain less than 65 per cent. of meat, the lowest being 56·5 per cent. The average meat content of the whole batch of 35 samples was 67·3 per cent. 3 samples contained preservative without the proper declaration.

Beef Sausages. 54 samples were taken. Only one contained less than 50 per cent. of meat, namely 40·5 per cent. The average meat content of the 54 samples was 64·9 per cent. 5 samples contained preservative without the proper declaration.

Creamed Sago Pudding. The label on the tin declared that the pudding was made with ‘milk’ whereas it was actually prepared with partially skimmed milk.

Fruit Curd must comply with The Food Standards (Preserves) Order; one requisite is that the Fruit Curd shall contain at least 65 per cent. of Soluble Solids. If the Soluble Solids fall below this proportion, the Curd has poor keeping qualities. One sample was below standard.

Stew Meat. A sample of stew meat was submitted because it developed a strong purple tint in the pan. We found that it contained a purple dye similar to that in copying and endorsing ink. Enquiries failed to find an explanation for its presence.

Commodities which had suffered through prolonged or unsuitable storage.

Baking Powder. One sample had lost a good deal of its 'available carbon dioxide' owing to the effect of dampness.

Coffee. One sample, packed in a cardboard drum with tin plate ends, had developed a peculiar taste and smell. Its moisture content was excessive and the tin plate ends of the container were spotted with rust. These details indicate that the deterioration was due to storage in a damp atmosphere. The packers were recommended to use airtight tins instead of cardboard drums.

Diabetic Plain Chocolate—this sample had developed a 'bloom' and was completely out of condition. The wrapper showed signs of dampness.

Sherbet Sucker. This consisted of a paper bag partly filled with sherbet powder, into which dips a tube of liquorice. The sample was no longer free-running and had lost most of its 'fizz', i.e. available carbon dioxide.

Sugar Cake Decorations. The sample consisted of a variety of cake decorations each in a plastic cup attached to the card. One variety, chocolate vermicelli, had suffered from dampness and was mouldy.

Prohibited Colouring Matters. All coloured foods are tested for colouring matters prohibited by The Colouring Matter in Food Regulations, 1957. Only one sample, a sugar cake decoration, was found to contravene these Regulations.

Labelling. Several infringements of The Labelling of Food Regulations were reported; the following are examples:—

Jam—marked 'Full Fruit Standard', whereas there is no provision for this term in The Food Standards (Preserves) Order.

Lard—in prepacked form; there was no registered trade mark nor name and address of packer or labeller.

Drugs—there were several cases of confusion; the letters 'B.P.' (meaning British Pharmacopoeia) being printed when the article should have been labelled 'B.P.C.' (British Pharmaceutical Codex).

Halibut Liver Oil Capsules—the container should be marked with the date of production. One sample was not marked in this manner.

Lists of Ingredients. Ingredients should be specified in the order of the proportion in which they are used, the ingredient used in the greatest proportion (by weight) being specified first. We are continually finding examples of failure to comply with this requirement.

Foreign Bodies. In the majority of cases, these 'foreign bodies' are discovered by the consumer who brings them to the Inspector.

Sometimes there is an element of excusability as when a stray fly has been found in an article of food; in these days of mass production it is virtually impossible to exclude such unpredictable objects, but the presence of a sizeable piece of tobacco can only be due to gross carelessness and irresponsible behaviour.

Hamburger. The sample contained a small stone.

Sliced Loaves. Two were submitted, one containing a piece of printed paper; the other contained a brown beetle $\frac{5}{16}$ in. long.

Iced Cake. Two samples; one containing a fly, the other a brown beetle.

Teacake. This contained tobacco, the clump of shreds being $\frac{1}{2}$ in. x $\frac{3}{4}$ in.

Cereal Food. This was infested with spider beetles.

Bilberry Pie. Whilst eating the pie, the consumer came across a black beetle amongst the bilberries. The beetle was slightly larger than the bilberries, and was of a type found on moors (*geotrupes stercorarius*) and may well have been imported with the bilberries.

Tins of Peas. Among the peas was a snail; its shell had been softened by the cooking process.

Additional Notes.

Ice Cream. 27 samples were genuine.

Dairy Ice Cream must be made with butter or cream. All 5 samples were genuine.

Hot Milk is occasionally found to contain ‘ added water ’ because it has been heated by steam, and sometimes because water has been put into the pan before the milk to prevent its burning. The one sample was genuine.”

A scheme is in operation whereby the County Council pays the fees of the Public Analyst for all samples of milk taken by Sampling Officers of the West Riding County District Councils in accordance with regulations made under the scheme, and also conducts all legal proceedings and defrays all consequential legal expenses. The number of samples submitted for analysis under the scheme was 201 of which only two were found to be below standard, both being deficient in fat.

Sanitary Circumstances:

WATER SUPPLIES:

Approximately 97 per cent. of dwelling houses within the Administrative County Area are supplied with water from public sources and 2.5 per cent. with satisfactory private supplies.

A summarised report on the activities during the year is appended below:—

	Districts with in-sufficiency of supply in certain cases	Districts with some unsatisfactory supply	Improvements effected	Improvements still required	Extensions effected	Extensions still required
Municipal Boroughs and Urban Districts...	16	13	23	12	29	14
Rural Districts ...	7	6	8	8	9	11

Samples Obtained

	Public Supplies				Private Supplies			
	Bacteriological		Chemical		Bacteriological		Chemical	
	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.
Municipal Boroughs and Urban Districts	1,993	85	567	3	274	219	26	—
Rural Districts ...	555	201	142	—	277	258	12	1

EXAMINATION OF WATERS KNOWN TO POSSESS PLUMBO-SOLVENT QUALITY:

The periodical examination of water from those public supplies in the West Riding which are known, or suspected, to possess plumbo-solvent properties has been carried out.

Two samples were collected from each supply (a) after standing for 30 minutes and (b) after standing all night in lead service pipes, the samples being examined for the presence of lead. It is generally considered that a water supply which is plumbo-solvent to the extent of taking up 1/10th of a grain or more per gallon is dangerous.

During the year 248 samples were obtained and in 2 instances lead in excess of 1/10th grain per gallon was reported, necessitating action to neutralise the water. Repeat samples were reported as satisfactory.

PRIVATE SUPPLIES OF WATER TO SPECIAL AND OTHER SCHOOLS:

Details of samples:

School	Source of Supply	Samples and Results of Bacteriological Examination	
		Satisfactory	Unsatisfactory
Grantley Hall Adult College, near Ripon	Land springs (chlorinated)	7	1
Ingleborough Hall Special School, Clapham, Settle	Lake (chlorinated)	5	—
Netherside Hall Special School, Grassington, Skipton	Land springs (chlorinated)	4	3
Hatfield Levels School, Thorne, near Doncaster	Bore, 202 feet deep (not chlorinated)	9	—

Appropriate action was taken regarding the unsatisfactory reports and attention to the chlorine dosage was given immediately.

The samples from Ingleborough Hall were obtained by the Chief Public Health Inspector, Settle R.D.C., to whom thanks are due for his co-operation.

DRAINAGE AND SEWERAGE:

The following is a summary of activities by the County Districts during the year:—

	Sewerage and Sewage Disposal:				Details of any parts of the Districts requiring:				
	Schemes, Extensions, etc. completed	Under construction at year end	Matters awaiting approval at year end	Matters in preparation at year end	Sewers	Improvement of defective Sewers	Sewage Disposal Works	Improvement or Extension of Sewage Disposal Works	Attention to storm water overflow
Municipal Boroughs and Urban Districts (68)	35	24	18	29	46	25	8	28	8
Rural Districts (21)	16	8	12	16	20	14	17	14	5

A number of premises are without adequate drainage and sewerage arrangements by reason of their scattered situation in the remote parts of the districts throughout the County area.

PUBLIC CLEANSING:

In the Municipal Boroughs and Urban Districts collections are mainly carried out every 7 days, in no case beyond 14 days. In Rural Districts collections vary between 7 and 28 days. Tipping on the controlled system, along with a few mechanical separation and incineration methods are found in the Municipal Boroughs and Urban Districts. In the Rural Districts both controlled and semi-controlled methods are employed.

CLOSET ACCOMMODATION:

Throughout the County by far the majority of closets are on the water carriage system although at the end of the year there were still a number of earth closets in use located in the outlying parts of districts. This number reduces year by year and in 1960, 1,418 conversions to water closets were effected.

ABATEMENT OF NUISANCES:

During the year 12,342 nuisances were abated by informal action. It was, however, necessary to issue Statutory Notices in certain instances which resulted in 1,527 subsequent abatements. In 9 cases legal proceedings were instituted to secure abatement of nuisances.

RURAL WATER SUPPLIES AND SEWERAGE ACTS, 1944-55:

The following applications for grants were made:—

District	Description of Scheme	Date of Application	Estimated Amount of Scheme
Doncaster R.D.	Sprotbrough Sewage Scheme	23rd November	£ 152,000
Kirkburton U.D.	Linfit and Gawthorpe Sewage Schemes	18th November	56,200
Nidderdale R.D.	Rufforth Sewerage and Sewage Disposal	24th February	11,138
do.	Boroughbridge Sewage Disposal Works, Enlargement	28th December	15,000
Osgoldcross R.D.	Cridling Stubbs Sewerage and Sewage Disposal	30th June	11,000
Penistone R.D.	Ingbirchworth Water Supply	28th June	7,967
do.	High Hoyland Sewerage and Sewage Disposal	28th June	27,250
Sedbergh R.D.	Sedbergh Sewage Works (Revised Scheme)	3rd May	13,625
Wharfedale R.D.	Farnley Sewerage Scheme	4th March	12,975
do.	Arthington Sewerage Scheme	6th May	9,235
Skipton R.D.	Lothersdale Sewerage and Sewage Disposal Scheme	28th April	17,990

HOUSING:

A summary of statistics relating to Housing is given below:—

Number of dwelling houses 552,462.

Number of Houses included in above: (a) Back-to-back 29,184.

(b) Single back 10,511.

Houses in Clearance Areas and Unfit Houses elsewhere:

Number of houses in Representations made:—

(a) in Clearance Areas 2,198.

(b) individual unfit houses 1,239.

Unfit Houses Closed

	Number	Displaced during year	
		Persons	Families
Under Sections 16(4), 17(1) and 35(1), Housing Act, 1957	498	935	342
Under Sections 17(3) and 26, Housing Act, 1957 ...	11	9	3
Parts of buildings closed under Section 18, Housing Act, 1957	31	50	18

Houses Demolished

	Houses Demolished	Displaced during year	
		Persons	Families
In Clearance Areas			
Houses unfit for human habitation	1,856	4,774	1,701
Houses included by reason of bad arrangement etc. ...	11	4	2
Houses on land acquired under Section 43 (2) Housing Act, 1957	41	76	32
Not in Clearance Areas			
As a result of formal or informal procedure under Section 17 (1) Housing Act, 1957	901	1,699	646
Local Authority owned houses certified unfit by the Medical Officer of Health	178	471	177
Houses unfit for human habitation where action has been taken under local Acts	—	—	—
Unfit houses included in Unfitness Orders	1	—	—

Unfit Houses made fit and Houses in which defects were remedied

	By Owner	By Local Authority
After informal action by local authority	9,713	568
After formal notice under:		
(a) Public Health Acts	1,042	115
(b) Sections 9 and 16, Housing Act, 1957	176	18
Under Section 24, Housing Act, 1957	11	—

Unfit Houses in Temporary Use (Housing Act, 1957)

	Number of houses	Number of separate dwellings contained in column (1)
	(1)	(2)
Position at end of year:		
Retained for temporary accommodation		
(a) Under Section 48	10	10
(b) Under Section 17 (2)	—	—
(c) Under Section 46	3	3
Licensed for temporary occupation under Sections 34 or 53	5	5

Purchase of Houses by Agreement

	Number of houses	Number of occupants of houses in column (1)
	(1)	(2)
Houses in Clearance Areas other than those included in confirmed Clearance Orders or Compulsory Purchase Orders, purchased in the year	239	563

Number of families rehoused into Council owned dwellings:

- (a) Clearance Areas etc. 2,597
- (b) Overcrowding 831

Rent Act, 1957

- (a) Number of certificates of disrepair granted 83
- (b) Number of undertakings to execute repairs given by owners to
the local authority 77
- (c) Number of certificates of disrepair cancelled 63

New Dwellings

Number of new dwellings completed:

By Local Authority 3,899. By Private Enterprise 6,230.

Grants for Conversion or Improvement of Housing Accommodation

	Formal applications received during the year	Applications approved during the year	Number of dwellings completed during the year
	Number of dwellings	Number of dwellings	
(a) <i>Conversions</i> (The number of dwellings is the number resulting from completion of the work)	114	116	119
(b) <i>Improvements</i>	4,738	4,387	3,668

The majority of County District Councils implemented the various Acts under which advances for the purpose of acquiring or constructing houses are permitted.

MOVABLE DWELLINGS:

Particulars of licensed sites and the number of caravans thereon are given in the subjoined table:

	Number of sites licensed for caravans for holiday and recreational purposes	Number of caravans on these sites	Number of sites licensed for caravans for residential purposes	Number of caravans on these sites	Number of caravans licensed individually
Municipal Boroughs and Urban Districts	45	1,035	47	365	103
Rural Districts ...	70	1,218	94	574	317

Atmospheric Pollution:

CLEAN AIR ACT, 1956:

Reports from the County Districts indicate that considerable activity has taken place in connection with the implementation of this Act.

In the industrial areas, in several instances, owners of boiler plant have co-operated with the County District officials in providing modern mechanical stoking equipment.

Routine observations have been made of works' chimneys and any infringement brought to the notice of the offenders.

Some districts report special problems in their midst arising from—colliery spoilbanks, firebrick manufacture, coke-ovens, lime-works, ceramic plant, grit, fumes etc., all of which it is hoped will in the near future be dealt with to obviate complaints.

The determination of a final scheme regarding miners' concessionary coal is still awaited and no doubt this will, when in operation, allow for the progress of Smoke Control Areas in the mining districts. A few districts have reported that this concessionary coal problem is definitely a deterrent in their areas.

The County Council, though not a "Local Authority" within the meaning of the Act, is still keenly interested in the problem of air pollution. There are two representatives appointed on the West Riding Clean Air Advisory Council and meetings are regularly attended for discussions regarding the multifarious problems arising.

The County Council's scheme for the measurement of atmospheric pollution has continued, working in close collaboration with the Department of Scientific and Industrial Research and Public Health Inspectors. During the year approximately 7,500 daily smoke filter stains were examined by the use of a reflectometer.

The results of analyses in connection with deposit gauges and lead peroxide instruments, along with the average daily suspended impurity as measured by the daily smoke filters, are shown in the following table:—

Situation of Instruments	Deposit Gauge			Sulphur Measurements by Lead Peroxide Method Milligrams SO ₃ per 100 sq. cms. per day—average	Situation of Daily Smoke Filter	Average Daily Suspended Impurity expressed in milligrams per 100 cubic metres
	Rainfall in inches		Total solids deposited in tons per sq. mile			
	Monthly Average	Total*	Monthly Average	Total*		
Settle—Malham Tarn Field Centre, open country	4.30	51.59	11.14	133.73	0.62	2
Skipton—Behind Town Hall in industrial and residential area	3.19	38.24	13.03	156.41	0.72	
Keighley—Abattoir, Hardings Road in mainly open country	3.19	38.25	14.86	178.31	1.48	19
Keighley—Oldfield, Oakworth in windy moorland country	3.08	36.97	11.97	143.64	1.42	
Keighley—Low Bridge, dense industrial area	3.24	35.63 for 11 months	16.66	183.27 for 11 months	1.46	
Keighley—Library, built-up area in centre of town	3.15	37.81	18.11	217.29	1.82 for 11 months	
Bingley—St. Ives Research Station in parkland and residential area	3.27	39.26	8.01	96.15	1.27	5
Bingley—Town Hall in manufacturing and residential area	3.10	34.13 for 11 months	17.65	194.16 for 11 months	0.81	
Shipley—Somerset House Clinic in manufacturing and semi-residential area	2.89	31.84 for 11 months	14.68	161.48 for 11 months	1.16	

Situation of Instruments	Deposit Gauge			Sulphur Measurements by Lead Peroxide Method Milligrams SO ₃ per 100 sq. cms. per day—average	Situation of Daily Smoke Filter	Average Daily Suspended Impurity expressed in milligrams per 100 cubic metres
	Rainfall in inches		Total solids deposited in tons per sq. mile			
	Monthly Average	Total*				
			Monthly Average				Monthly Average	Total*
Aireborough — Yeadon Moor, Yeadon Waterworks. Agricultural N.W. to S.E., manufacturing S.E. to W.	2.71	32.56	11.55	138.65	1.35	14
Horsforth—Broadgate Walk, residential area	2.77	33.23	15.87	190.49	1.40	
Otley—Nursery Gardens, Westgate, manufacturing and semi-residential	3.11	37.34	11.71	140.56	0.80	9
Ripon—Corporation Depot, Low St. Agnesgate, residential and industrial area	2.59	31.07	9.48	113.79	0.63	13
Harrogate—Roof of Municipal Offices, residential and commercial. Inland Spa	3.61	43.34	10.60	127.14	1.04	10
Wetherby—Council Offices, residential, surrounded by open country from ½ to ¾ mile distant	2.65	31.85	9.71	116.53	0.79	7
Goole — Bartholomew Avenue Clinic, residential and industrial	2.04	24.46	7.93	95.21	1.24	13

* For period of full year.

Situation of Instruments	Deposit Gauge			Sulphur Measurements by Lead Peroxide Method	Situation of Daily Smoke Filter	Average Daily Suspended Impurity expressed in milligrams per 100 cubic metres
	Rainfall in inches	Total solids deposited in tons per sq. mile				
	Monthly Average	Total*	Monthly Average	Total*			Milligrams SO_{3} per 100 sq. cms. per day—average
Castleford—Roof of Marks & Spencer's shop, Carlton Street, in centre of industrial town	2.56	30.67	15.10	181.25	2.05	27
Castleford—Roof of Cleansing Station, Cinder Lane, manufacturing area. Chemical works immediately adjacent	2.20	24.23 for 11 months	28.24	310.63 for 11 months	2.33	
Castleford — Corpn. Pumping Station, Ings Lane, manufacturing area	2.33	27.90	18.97	227.67	1.79	
Castleford—Corpn. Housing Depot, Redhill Road, Airedale. Industrial and residential area	2.44	29.31	10.66	127.94	1.84	
Horbury—Carr Lodge Park, residential and manufacturing to north, open country to south	2.98	35.70	15.08	180.91	1.72	11
Morley—Public Health Inspector's Dept., Commercial Street, residential, commercial and manufacturing	3.17	38.06	16.13	193.54	1.18	23

Situation of Instruments	Deposit Gauge			Sulphur Measurements by Lead Peroxide Method	Situation of Daily Smoke Filter	Average Daily Suspended Impurity expressed in milligrams per 100 cubic metres
	Rainfall in inches		Total solids deposited in tons per sq. mile			
	Monthly Average	Total*	Monthly Average	Total*		
Batley—Public Health Dept., Market Place, in centre of mixed residential, commercial and manufacturing area	3.20	38.38	26.21	314.48	Public Health Dept., Market Place, in centre of mixed residential, commercial and manufacturing area	24
Rothwell—Central Clinic, Oulton Lane, residential	2.49	29.83	12.14	145.68	Div. Health Office, Oulton Lane, residential	19 for 11 months
Spensorough—Corpn.'s Depot, Marsh. North, south and west—manufacturing area, open country to east	2.95	35.44	17.06	204.73	Div. Health Office, Elm Bank, in industrial and manufacturing area	15 for 10 months
Elland—"Ellen Royd," Public Library, in manufacturing area	3.63	43.53	17.34	208.09	First floor of Council Offices, in manufacturing area	18
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area, open country to north	3.93	47.13	12.62	151.41	Redacre Sewage Works, Mytholmroyd, residential and manufacturing area, open country to north	10
Colne Valley—Roof of Fire Station, Slaithwaite, in centre of mixed residential and textile manufacturing district	3.83	45.98	15.68	188.12	† The new Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing district	15 for 11 months
Colne Valley—Marsden Park, residential and manufacturing area	4.03	48.40	13.66	163.95		

* For period of full year.

† The instrument was previously at Town Hall, and was moved to present site on 20th May, 1960.

Situation of Instruments	Deposit Gauge			Sulphur Measurements by Lead Peroxide Method Milligrams SO ₃ per 100 sq. cms. per day—average	Situation of Daily Smoke Filter	Average Daily Suspended Impurity expressed in milligrams per 100 cubic metres
	Rainfall in inches		Total solids deposited in tons per sq. mile			
	Monthly Average.	Total*	Monthly Average			
Holmfirth—Sewage Works, Neiley, Brockholes, residential and manufacturing	3.53	42.34	13.48	161.79	0.98	
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield, residential, manufacturing and commercial	3.30	39.61	10.07	120.85	1.37	9
Wortley—Hallwood Hospital Grounds, Grenoside, open country and woodland	2.84	34.08	8.96	107.48	1.08	12
Hemsworth—Vale Head Park, parkland, surrounded by open country	2.42	29.07	12.22	146.62	1.48	15
Darton—Grounds of Council Offices, semi-residential, colliery district. Coke by-product plant 1 mile to S.E.	3.02	36.18	9.67	115.99	0.97	9
Wombwell—The Gables, semi-residential, colliery district	2.95	35.40	15.29	183.49	1.33	23
Rawmarsh—Roof of Clinic, Barbers Avenue, residential and industrial	2.95	29.54 for 10 months	31.43	314.34 for 10 months	1.81	30

Situation of Instruments	Deposit Gauge				Sulphur Measurements by Lead Peroxide Method Milligrams SO ₃ per 100 sq. cms. per day—average	Situation of Daily Smoke Filter	Average Daily Suspended Impurity expressed in milligrams per 100 cubic metres
	Rainfall in inches		Total solids deposited in tons per sq. mile				
	Monthly Average	Total*	Monthly Average	Total*			
Rawmarsh—Grounds of Granby House, Aldwarke Road. Blast furnaces 200-300 yards distant	2.59	31.06	185.54	2,226.50	2.31		
Bentley with Arksey—Bentley Park, Askern Road, semi-residential, colliery district	2.34	28.03	13.30	159.58	0.85	Council Offices, in centre of residential area, colliery district	14 for 11 months
Doncaster—Between Church & Vicarage, Askern. Industrial and residential, colliery district	1.74	17.39 for 10 months	19.12	191.22 for 10 months	1.08		
Thorne—Grounds of Council Offices, semi-residential, colliery district	1.93	21.23 for 11 months	17.78	195.59 for 11 months	1.11	Council Offices, semi-residential, colliery district Maltby—Council Offices, one mile west of town centre, semi-residential, colliery district	10 10
* For period of full year unless stated otherwise.		Situation of Volumetric Sulphur Dioxide Apparatus				Sulphur Measurements by Volumetric Method	
						SO ₂ in parts per 100 million—daily average	
		Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area, open country to north				2.6	
		Aireborough—Public Health Inspector's Office, Yeadon High Street, residential to W., open country to E.				3.2	

DETAILS OF SMOKE CONTROL AREAS:

Declared during the year	Premises Affected	Acreage Affected	Confirmed during the year	Premises Affected	Acreage Affected
25	8,703	2,381	13	3,945	1,153

Swimming Baths and Bathing Pools:

District	Public Baths or Pools	Pri- vately Owned Baths or Pools open to the Public	Baths Exclusive to Schools		Padd- ling Pools	Remarks	Samples for Bacterio- logical Examination	
			Nor- mal type	Lear- ners' type			Sat.	Unsa-
Municipal Boroughs:								
Batley	2	—	—	—	1	Filtered and chlorinated. Paddling pool periodically drained and cleaned	2	—
Brighouse	1	—	—	—	—	Filtered and chlorinated	19	3
Castleford	1	—	—	—	—	“ Breakpoint ” chlorination etc.	22	—
Goole	1	—	—	—	—	Filtered and chlorinated	9	—
Harrogate	2	—	3	—	1	Public indoor baths are filtered and chlorinated. School baths—one with filtration and chlorination plant, one with filtration and chlorination plant in hand, and one with chlorination only. Paddling pool water changed weekly in summer	50	1
Keighley	1	—	—	—	—	Chloramination treatment in use	5	—
Morley	2	—	—	—	—	Filtered and chlorinated	80	2
Pontefract	2	—	—	—	—	Town's water. Filtered and chlorinated	87	4
Pudsey	1	—	—	—	—	Filtered and chlorinated	2	—
Ripon	1	—	1	—	1	Public bath filtered and chlorinated. Others emptied, cleansed and refilled as required	—	—
Spenborough	1	—	—	—	—	Filtered and chlorinated	8	1
Todmorden	—	—	1	—	1	Filtered and chlorinated at school bath	1	—

District	Public Baths or Pools	Privately Owned Baths or Pools open to the Public	Baths Exclusive to Schools		Paddling Pools	Remarks	Samples for Bacteriological Examination	
			Normal type	Learners' type			Sat.	Unsat.
Urban Districts:								
Aireborough	—	—	2	—	—	Both baths have filtration and chlorination	1	—
Bentley with Arksey	—	—	—	—	1	Cleansed regularly by hosing. Frequent water changes	—	—
Bingley	1	—	—	—	1	Filtered and chlorinated. Improvements have been made at paddling pool	18	—
Conisbrough	1	—	—	—	—	Town's water. Filtered and chlorinated	6	—
Cudworth	1	—	1	—	1	Town's water, filtered and chlorinated for bath. Others seasonal use only	—	—
Dearne	1	—	—	—	—	Town's water. Filtered and chlorinated	6	4
Denby Dale	—	1	—	—	—	Miners' Welfare Baths. Filtered and chlorinated	10	4
Earby	—	—	—	—	1	Water from stream	—	—
Elland	1	—	—	—	—	Filtered and chlorinated. Periodical chemical and bacteriological examination of water	2	—
Featherstone	1	—	—	—	—	Town's supply, filtered and chlorinated	30	12
Hebden Royd	—	—	—	—	1	Town's water, changed weekly, cleaned out and chlorinated frequently	—	2
Heckmond-wike	1	—	—	—	—	Filtered and chlorinated	6	—
Hemsworth	—	—	—	—	1	Continuous flow from small stream	—	—
Horbury	—	—	—	—	1	Water changed every 10 days. Sterilisation by Quaternary Ammonium. Frequent bacteriological tests made	—	—
Ilkley	1	—	1	—	1	Public bath filtered and chlorinated	—	—

District	Public Baths or Pools	Privately Owned Baths or Pools open to the Public	Baths Exclusive to Schools		Paddling Pools	Remarks	Samples for Bacteriological Examination	
			Normal type	Learners' type			Sat.	Unsat.
Knaresborough	—	—	—	—	1	Small pool, emptied and cleansed weekly, twice-weekly in summer	—	—
Maltby	1	—	—	—	1	Open-air pool with "Breakpoint" chlorination. Paddling pool disused	3	—
Mirfield	—	—	—	—	1	Frequently emptied and refilled during summer	—	—
Normanton	1	—	—	—	—	"Breakpoint" chlorination	22	—
Otley	1	—	—	1	1	Public bath filtered and chlorinated. Learners' pool has sand filter and chemical sterilisation. Paddling pool constant flow via weir	—	—
Queensbury and Shelf	1	—	—	—	—	Filtered and chlorinated	—	—
Rawmarsh	1	—	—	—	1	Filtered and chlorinated bath water. Paddling pool sterilised by hand daily	5	—
Selby	1	—	—	—	—	Filtered and chlorinated	2	—
Shipley	1	—	—	—	—	Town's water, filtered and chlorinated	12	—
Skipton	1	—	1	—	—	Filtered and chlorinated	23	—
Sowerby Bridge	1	—	—	—	2	Bath, filtered and chlorinated. Paddling pools, water changed weekly	4	—
Stanley	—	—	1	—	—	School bath in use during summer only. Mains water changed weekly	—	—
Wath upon Dearne	1	—	—	—	—	Filtered and chlorinated	9	1
Wombwell	1	—	—	—	—	Filtered and chlorinated. Filters to be replaced in 1961	27	24

District	Public Baths or Pools	Privately Owned Baths or Pools open to the Public	Baths Exclusive to Schools		Paddling Pools	Remarks	Samples for Bacteriological Examination	
			Normal type	Learners' type			Sat.	Unsat.
Rural Districts:								
Doncaster	—	1	—	—	1	N.C.B. pool. Water from steam raising plant system. Hand chlorination. Automatic chlorination plant under consideration	2	10
Hemsworth	1	—	1	—	—	Both mains water. Regular samples taken for chlorine content	36	—
Kiveton Park	—	1	—	—	—	Filtered and chlorinated	1	—
Nidderdale	—	1	—	1	—	Hotel pool and school bath filtered and chlorinated	2	1
Ripon and Pateley Bridge	—	—	—	1	1	Learners' bath from public mains, chlorinated	2	—
Sedbergh	—	—	1	—	—	Filtered and chlorinated. Sampled by school authorities	—	—
Settle	—	1	1	—	—	Open-air pool on river side, untreated water. Indoor school bath has private chlorinated water	—	—
Skipton	—	2	2	—	2	Two privately-owned baths use mains water, filtered and chlorinated. One school bath has chlorinated water from private source the other from public mains. Hand chlorination used in both cases	86	9
Tadcaster	—	—	—	—	1	Bathing point in River Wharfe is used	—	—
Thorne	—	1	—	—	1	Private pool chlorinated and regular tests by owner. Paddling pool is under supervision of the Thorne Parish Council, treated and tested daily	—	—
Wetherby	—	—	—	1	1	Learners' pool chlorinated	—	—
Wharfedale	—	—	—	1	—	Private water, chlorinated and changed weekly when in use	—	—

Summary of Visits and Duties carried out by the County Public Health Inspectors:

Inspections at dairies under The Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53 and The Milk (Special Designation) Regulations, 1960	...	...	...	...	...	400
Samples of pasteurised and sterilised milk obtained	...	...	...	...	...	384
Visits in connection with The Milk (Special Designation) Regulations, 1960	...	...	...	...	...	85
Food and Drugs Act—"Specified Areas" for the retail sale of milk, enquiries made	...	...	...	...	...	700
Visits to school milk contractors	...	...	...	...	...	15
Samples of school milk obtained	...	...	...	...	...	147
Samples of hospital farm milks obtained (on behalf of the Ministry of Health)	...	...	...	...	...	19
Court proceedings regarding "Specified Area" offence	...	...	...	...	...	1
Inspections in connection with The Housing (Rural Workers) Acts	...	...	...	...	...	50
Housing complaint investigated	...	...	...	...	...	1
Water supplies investigations	...	...	...	...	...	3
Ministry inquiry regarding water supply	...	...	...	...	...	1
Visits to Special and other schools regarding water supplies, including sampling	...	...	...	...	...	30
Visits regarding "Learners'" swimming pools at schools	...	...	...	...	...	4
Investigation regarding sewerage matter	...	...	...	...	...	1
Investigations regarding infestations by rats and mice at school kitchens	...	...	...	...	...	12
Pig-keeping complaints investigated	...	...	...	...	...	3
Inspections under The Pharmacy and Poisons Acts	...	...	...	...	...	275
Meetings of the West Riding Clean Air Advisory Council attended	...	...	...	...	...	5
Smoke abatement matters dealt with	...	...	...	...	...	5
Daily smoke filter papers examined by reflectometer	...	...	...	...	...	7,500
Investigations regarding powdered paints used in schools	...	...	...	...	...	3
Visits to County Analyst	...	...	...	...	...	2
Meetings with Divisional Medical Officers, Public Health Inspectors etc.	...	...	...	...	...	35

PART VI

MISCELLANEOUS

**Welfare of the Epileptic and Spastic
Certification and Treatment of Blind
and Partially Sighted Persons**

National Assistance Act, 1948

Residential Accommodation

**Disabled and Old Persons'
Homes**

**Persons in need of Care and
Attention**

Registration of Nursing Homes

Notification of Births

**Nurseries and Child-minders Regulation
Act, 1948**

**Medical Arrangements for County Children's
Homes and Residential Nurseries**

Medical Examination for Superannuation

THE WELFARE OF THE EPILEPTIC AND SPASTIC

The following are the particulars of known epileptics and spastics:

<i>Adults</i>		<i>Number</i>	
		<i>Epileptics</i>	<i>Spastics</i>
1.	Provided with accommodation under Part III of the National Assistance Act, 1948:		
(a)	in homes for epileptics 	65*	
(b)	in homes for spastics and other handicapped persons 		20†
(c)	in County establishments and establishments where County Council has "right of user" 	45	
*Cookridge Hall Epileptic Home, Leeds was opened in December, 1955, and accommodates 19 West Riding cases. Plans for the Home's future development are now proceeding.			
†Several cases awaiting admission to Spastic Homes.			
2.	Registered under the County Council's scheme of Welfare Services for Handicapped Persons (General Classes) 	100	98

Children

Number ascertained as handicapped:

(a)	Approximate number attending ordinary schools	Not known	101
(b)	Attending special schools 	20	94
(c)	Receiving home tuition 	—	5
(d)	Attending Training Centres for the Mentally Subnormal 	30	29

The register of handicapped persons, including epileptics and spastics, under the approved scheme has been kept up to date and the information recorded includes the medical classification and assessment of their suitability for employment. Again much thought has been given during the year to furthering the County Council's approved scheme under Sections 29 and 30 of the National Assistance Act, 1948. A few centres are being operated through the County Council and the agency of voluntary organisations in the County Boroughs and these generally serve handicapped persons in the contiguous West Riding areas. In addition local branches of the National Spastics Society are now operating in several districts of the West Riding, at York, Leeds, Bradford, Halifax, Dewsbury, Huddersfield, Barnsley, Sheffield, Pontefract, Castleford and Goole. Social and handicraft centres have been established at Harrogate, Morley, Pontefract, Wombwell and Ripon.

There were six full-time handicraft instructresses working in the County during the year. From this agency over 685 handicapped persons were actively engaged in home handicraft work and of this number 43 were epileptics and 44 were spastics. There are numerous avenues for the disposal by sale of the articles produced; some are disposed of by private arrangements of the persons concerned, and assistance is afforded to others to obtain orders and sales. Voluntary organisations and many persons of goodwill have been helpful in providing means of sale and their assistance is gratefully appreciated.

Again advice to handicapped persons on their various problems and assistance and liaison with other statutory bodies is effected through nine Divisional Welfare Officers.

Financial assistance was given to handicapped persons (including a number of spastics) in respect of internal and/or external adaptations to their homes or in respect of the provision of additional facilities designed to secure their greater comfort or convenience.

The County Council made grants to organisations providing voluntary services for handicapped persons and grants were made to the Spastic and Epileptic Societies.

CERTIFICATION AND TREATMENT OF BLIND AND PARTIALLY SIGHTED PERSONS

The following table gives particulars of new registrations during 1960 of blind and partially sighted persons (other than handicapped school children).

	Disability (B.—Blind, P.S.—Partially Sighted)									
	Cataract		Glaucoma		Retro-lental Fibroplasia		Others		Total	
	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(i) Number of cases registered during the year in respect of which Section F recommends:										
(a) No treatment	95*	33	23	—	1	—	109	32	228	65
(b) Treatment (medical, surgical, optical or hospital supervision)	166†	113=	21	6	—	—	88	57	275	176
(ii) Number of cases at (i) (b) above which received treatment ...	104	60	18	5	—	—	71	45	193	110

* Includes 11 cases of cataract with glaucoma.

† Includes 15 „ „ „ „ „

= Includes 25 „ „ „ „ „

RESIDENTIAL ACCOMMODATION

(National Assistance Act, 1948)

Under the scheme for residential accommodation the County Medical Officer is responsible for the general medical oversight of the following:—

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>	
			<i>Men</i>	<i>Women</i>
The Shroggs, Skipton Road, Steeton	Miss E. M. Wolstenholme	Steeton 3213	—	20
Farfield Hall, Bolton Road, Addingham	Mrs. H. Otter	Bolton Abbey 241	11	19
Sharow View, Allhallowgate, Ripon	Mr. and Mrs. E. Brook	Ripon 238	42	30
The Beeches, Leeds Road, Tadcaster	Mr. and Mrs. H. G. Jenner	Tadcaster 2113	66	40
*11, Stockwell Road, Knaresborough	Miss W. M. Brown (Matron) Mr. T. K. Hayward (Secretary)	Knaresborough 2283	54	33
Wharfedale Lawn, Westgate, Wetherby	Miss D. E. Pearson	Wetherby 2446	—	23
The Grove, 80, High Street, Starbeck	Mrs. H. Johnson	Harrogate 83980	—	19
Hillworth Lodge, Oakworth Road, Keighley	Mr. and Mrs. P. Rawlin	Keighley 4014	73	129
Thornton View, Thornton View Road, Pasture Lane, Clayton, Bradford	Mr. and Mrs. F. Innis	Queensbury 2007/8	100	101
Woodville, Spring Gardens Lane, Keighley	Miss L. C. Wilks	Keighley 2428	9	11
Crow Trees, Leeds Road, Rawdon	Mrs. H. M. Lewis	Rawdon 908	—	20
Burley Hall, Burley in Wharfedale, near Ilkley	Miss E. S. Atkinson	Burley in Wharfedale 2334	7	20
Park House, 41, Lister Lane, Bolton, Bradford	Mr. and Mrs. G. H. Fletcher	Bradford 39913	22	—
Glenholme, Green Lane, West Vale, Greetland	Mr. and Mrs. H. H. Senior	Elland 2985	20	20
Stoneswood, Oldham Road, Delph	Miss M. C. Murphy	Delph 300	8	12

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>	
			<i>Men</i>	<i>Women</i>
Longlands, Leeds Road, Lightcliffe, near Halifax ...	Miss A. Dickinson	Halifax 68254	8	12
Scaitcliffe Hall, Burnley Road, Todmorden	Miss L. Holt	Todmorden 114	10	14
Stanley View, Park Lodge Lane, Wakefield	Mr. and Mrs. F. W. Radley	Wakefield 2188	148	94
Beech Towers, Halifax Road, Staincliffe, near Dewsbury	Mr. and Mrs. N. W. Jones	Dewsbury 28	177	134
Walton House, Shay Lane, Walton, near Wakefield ...	Mrs. D. Wright	Wakefield 5242	—	20
Turnsteads, Whitcliffe Road, Cleckheaton	Mrs. M. T. Briggs	Cleckheaton 2972	—	23
Brook Lodge, Brook Street, Selby	Mr. and Mrs. J. E. Whitworth	Selby 15	64	70
Northgate Lodge, Skinner Lane, Pontefract	Mr. and Mrs. C. Borrill	Pontefract 3351/2	100	64
Wadworth Hall, Wadworth, near Doncaster	Miss M. Bakewell	Doncaster 53272	9	18
Don View, 22, Thellusson Avenue, Scawsby, near Doncaster	Mr. and Mrs. C. Storey	Doncaster 2257	15	23
Rolleston House, High Street, Maltby	Mr. and Mrs. G. T. Nutt	Maltby 118	18	25
Oaklands, Oakdale, Worsbrough Bridge	Mr. and Mrs. I. B. MacDonald	Barnsley 5928	18	25
Netherfields, Sheffield and Halifax Road, Penistone ...	Mr. and Mrs. T. W. H. Lambert	Penistone 2144	37	29
Wombwell Grange, Park Street, Wombwell	Mrs. K. M. Smith	Wombwell 2186	—	17

* County Council have "right of user."

REGISTRATION AND INSPECTION OF DISABLED AND OLD PERSONS' HOMES

(*National Assistance Act, 1948*)

The following premises, which are inspected in conjunction with the officers of the Welfare Department, are registered as Disabled and Old Persons' Homes.

<i>Establishment</i>	<i>Number of Residents</i>	<i>Type of Home *(Part I II or III)</i>
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis, Doncaster ...	23	I
Mrs. Bessie Fox, Moor Lane House, Moor Lane, Gomersal...	10	I
Harrogate Old People's Home, 66-68, Cold Bath Road, Harrogate ...	36	I
Skelldale Housing Society Ltd., Borrage House, Borrage Lane, Ripon	12	I
Ernest Ayliffe Home for the Deaf and Dumb, Fulford Grange, Rawdon	30	II
North Regional Association for the Blind, "Oaklands," Huddersfield Road, Holmfirth ...	30	II
Keighley & District Institute for the Blind, 13-15, Scott Street, Keighley	17	II
Mrs. M. L. Harris, The Woodlands, Farrer Lane, Oulton ...	21	I
Methodist Homes for the Aged, "Glen Rosa," Grove Road, Ilkley...	32	I
Methodist Homes for the Aged, Berwick Grange, 5, Otley Rd., Harrogate	34	I
Highfield Home for the Blind, Soothill Lane, Batley ...	14	II
Catholic Women's League, Clitherow House, 49, Valley Dr., Harrogate	16	I
Miss L. W. Miller, "Greylands," Forest Moor, Knaresborough ...	7	I
Miss Anna F. Schramm, "Moor Top," 43, Harlow Moor Drive, Harrogate ...	8	I
Mrs. I. Brearley, S.R.N., Haversham Court, Ben Rhydding Road, Ilkley	28	III
Mrs. R. Gratton, Gratton Home for Aged Ladies, 11, East View Terrace, Otley ...	14	I
Mrs. A. C. Shepley, Batley Hall, Upper Batley ...	10	I
Harrogate Guild of Help (Avondale Trust Ltd.), "The Avondale," Cold Bath Road, Harrogate ...	20	I
Mrs. K. D. Clarke, "Newlands," 58, Harlow Moor Drive, Harrogate	5	I
Yorkshire Association for the Care of Cripples, St. George's House, Otley Road, Harrogate ...	70	II
Mr. William Kneen, The Gables, Norland, Sowerby Bridge ...	11	I
Mrs. M. Fell, Oakfield, Thwaites Brow, Keighley ...	5	I
Mrs. B. M. Veall, Lansdown, 46, Kent Road, Harrogate ...	12	I
Mrs. Rhoda Herrington, 6, Lancaster Park Road, Harrogate ...	3	I
Mrs. Blanche Heal, "Burnlee House," Park Head, Holmfirth ...	9	I
Mrs. Eileen Ann Sweeting, 14, Alexandra Road, Harrogate ...	10	I
Mrs. Minnie Satariano, "Downside," 15, Otley Road, Harrogate ...	15	I
Mrs. Queenie Mona Marsh, Portland House, 14, Leeds Rd., Harrogate	6	I
Mrs. P. C. Rayfield, The Grange, Woodlesford, near Leeds ...	5	I
Mrs. Alice McConney, Elm Bank, 242, Park Lane, Keighley ...	8	I
Mrs. June Valentine Minogue, Straygarth, 42, York Place, Harrogate	16	I
Mr. Douglas Kneen, Thorpe House, Triangle, near Halifax ...	12	I
Mrs. Doreen May Thompson, Brooklands, Harper Lane, Yeadon ...	6	I
W. H. and R. E. Higgins, Housley Manor, Housley Hall Lane, Chapeltown ...	14	I
Pentecostal Eventide Housing Association, Brooklands, Bakewell, Pentecostal Eventide Home, Bradford Road, Wrenthorpe ...	30	I
Mrs. Hester Walker, Granville House, Exley Road, Keighley ...	9	III
Mrs. A. G. Turner and Miss G. Carradice, Ghyll Court, The Wells Walk, Ilkley ...	12	I
Mrs. K. M. Pay, 60, Franklin Road, Harrogate ...	5	I
Mr. F. Vasey (Kildare Lodge Ltd.), Kildare Lodge, 23, Park Drive, Harrogate ...	9	I
Mrs. Mary Morrison, Pembury, 44, St. Mark's Avenue, Harrogate ..	4	I
Miss Beatrice Anne Hartley, Hartwell Home, Raincliffe, Thorpe Hesley	18	I
Mrs. Freda Mary Hodge, The Redlands, 21, Grove Road, Harrogate	6	I
Keighley and District Institution for the Blind, Home for the Blind, Westfield, Bromley Road, Bingley ..	16	II
<i>Incorporated by Royal Charter</i>		
Lister House, Sharow, near Ripon ...	70	III
	approx.	(and Hospital cases)

* Part I—Homes for Old Persons
 Part II—Homes for Disabled Persons.
 Part III—Homes for Old and Disabled Persons.

In 1956, all County District Councils were informed that the County Council were prepared to consider the making of contributions under Section 126 of the Local Government Act, 1948, towards the expenses incurred by them in the development of services for aged persons accommodated on Council estates subject to the submission of schemes containing full details of the proposals and subject also to the aged persons who are to be accommodated being those who are likely to require residential accommodation in the foreseeable future, such persons being selected in conjunction with the Divisional Medical Officer and the Divisional Welfare Officer.

Subsequently, Circular 18/57, issued by the Minister of Housing and Local Government on 18th March, 1957, gave general consent to the making of contributions by County Councils under the Section referred to above towards the whole or any part of any expenses incurred in the provision of housing vital to the needs of old people by housing authorities, subject to such contributions not exceeding £30 per house per annum, special sanction being required in respect of proposed contributions above that figure.

During the period July, 1957 to January, 1961, 130 schemes have been approved by the County Council, affecting 42 District Councils.

I am indebted to Mr. F. B. Armstrong, County Welfare Officer, for supplying most of the foregoing information in this Part of the Report.

REMOVAL TO SUITABLE PREMISES OF PERSONS IN NEED OF CARE AND ATTENTION

Section 47 of the National Assistance Act, 1948, empowers Medical Officers of Health to initiate proceedings for persons suffering from grave chronic disease or being aged, infirm and living in insanitary conditions to be compulsorily removed to hospital or Part III accommodation. In cases of emergency action may be taken under the National Assistance (Amendment) Act, 1951.

From the reports of Medical Officers of Health it is apparent that these powers are used with the utmost reluctance. The proceedings, resented by the person involved and intensely disliked by every official concerned, are, however, unavoidable in certain instances. It was necessary to remove compulsorily three women and one man to hospital, also seven women to accommodation provided under Part III of the National Assistance Act, 1948.

REGISTRATION OF NURSING HOMES

(Public Health Act, 1936—Sections 187-195)

There was 1 amended registration, together with 2 cancellations, making a total of 34 homes registered, providing 11 beds for maternity and 383 beds for other cases. Thirty-two visits of inspection were carried out. The following schedule gives brief details of the nursing homes in the area on the 31st December.

<i>Name and Address of Nursing Home</i>	<i>No. of Beds Registered</i>		<i>Other Information</i>
	<i>Maternity</i>	<i>Other</i>	
Brooklands Nursing Home, Long Preston	3	7	Occasional midwifery cases only
Sunnybank Nursing Home, Braithwaite, Keighley ...	—	6	
Blue Dawn Nursing Home, Priesthorpe Lane, Bingley	—	20	
Thornfield Nursing Home, Micklethwaite, near Bingley	2	8	
Elmhurst Nursing Home, Hall Bank Drive, Bingley	—	6	
Jesmond Nursing Home, New Street, Farsley, Pudsey	—	7	
The Hawthorns Nursing Home, Outwood Lane, Horsforth, Leeds	—	16	Generally hospital convalescent cases
St. Joseph's Convalescent Home, Outwood Lane, Horsforth, Leeds	—	16	Ditto.
Fairholme Nursing Home, Ilkley	—	14	
Westleigh Nursing Home, Pool in Wharfedale, Leeds	—	4	
Chevin Hall Nursing Home, Otley	—	24	
Ure Lodge Nursing Home, Ure Bank Terrace, Ripon	—	21	
Clova Nursing Home, Clotherholme Road, Ripon ...	—	15	
Staffa Nursing Home, 5, Coppice Drive, Harrogate	—	3	
Cavendish Nursing Home, 17, Cavendish Avenue, Harrogate	—	7	
Alexandra Nursing Home, 7, Alexandra Road, Harrogate	—	8	
Alderson Nursing Home, 2, Alderson Square, Harrogate	—	6	
Duchy House Clinic, 9, Queen's Road, Harrogate ...	—	22	Operating theatre, X-rays, pathological investigations
Nursing Home, 2, East Park Road, Harrogate ...	—	2	No further admissions to be made
Windermere Nursing Home, 1a, Westcliffe Grove, Harrogate	—	1	
The Pines Nursing Home, 57, Harlow Moor Drive, Harrogate	—	14	
Norman Lodge Nursing Home, 58, Kent Road, Harrogate	—	25	
Beech Grove Nursing Home, 1, Beech Grove, Harrogate	—	8	
Courtfield Nursing Home, 3, St. James Drive, Harrogate	—	14	
Hereford Nursing Home, 16, Hereford Road, Harrogate	—	16	
Westfield Nursing Home, Killinghall, Harrogate ...	—	7	
Kingsley Nursing Home, 38, Ripon Road, Harrogate	—	5	
Strathroy Nursing Home, 115, Franklin Road, Harrogate	—	8	
Cheshire Foundation Home, Spofforth Hall, Spofforth	—	21	
Benton Nursing Home, Benton Hill, Horbury ...	6	—	
Cross Brook Nursing Home, Todmorden	—	8	
White Windows (West Riding Cheshire Home), Sowerby Bridge	—	30	
Woodend Nursing Home, Atherton Street, Springhead	—	12	
Glenhaven Nursing Home, 35, Cusworth Lane, Sprotbrough	—	2	

NOTIFICATION OF BIRTHS

(Public Health Act, 1936, Section 203)

Notifications were received relating to 20,545 live and still births occurring in the Administrative County Area, and of 10,801 births occurring elsewhere to mothers who were normally resident in the County. The former figure included 2,658 births to mothers not normally resident in the County Area, and the consequent net total of births notified and attributable to the County Area was 28,688. When this figure is compared with the Registrar General's return of 28,576 births (27,935 live and 641 still births) in the County Area, the degree of error is slight and affords satisfactory evidence of the effectiveness of the system of notification. Prompt notification makes it possible to arrange for the early visitation of the newly-born babies by the health visitors and it is satisfying to record that they paid 26,797 first visits to children under one year of age, representing 96 per cent. of the total live births.

NURSERIES AND CHILD-MINDERS REGULATION ACT, 1948

Applications for the registration of one nursery and nine child-minders were approved, and at the end of the year, there were five nurseries registered for the care of 130 children and fifteen child-minders caring for a total of not more than 81 children.

MEDICAL ARRANGEMENTS FOR COUNTY CHILDREN'S HOMES AND RESIDENTIAL NURSERIES

Divisional Medical Officers have submitted periodic reports on the discharge of their responsibilities for the medical arrangements at County Children's Homes and Residential Nurseries; these provide for the medical examination of children on admission and discharge, subsequent routine and special examinations, the keeping of medical records, precautions against the spread of infectious diseases, determining the hours of rest and sleep, the general supervision of health, hygiene and dietary, and the staffing of the nurseries. Routine examinations, which are undertaken monthly in residential nurseries and six-monthly in children's homes, reveal the not-unexpected high proportion of children with physical and mental defects, and with emotional problems.

MEDICAL EXAMINATION FOR SUPERANNUATION

An appointment to a superannuable post is subject to the applicant passing a medical examination. The examinations are carried out by Medical Officers on the County Council's staff except where the successful candidate resides far outside the geographical County when arrangements are made either for examination by another Local Authority on a reciprocal basis or by a medical practitioner, the fee of 37s. 6d. in the latter case being paid by the County Council. In cases where the medical certificate proves inconclusive a consultant's opinion is obtained at the expense of the County Council and the findings are made available to the family doctor.

During the year 1,603 persons were medically examined as set out in the table below and of these 47 were not considered medically suitable for admission to the Superannuation Scheme.

Examined by County Council Medical Officers	...	...	...	1,509
Examined by Medical Officers of other Local Authorities	...	...	...	59
Examined by General Practitioners	...	...	...	35

In 10 cases a consultant's opinion was obtained.

In addition 77 special medical examinations were arranged at the request of employing departments and 28 medical examinations were undertaken at the request of other Local Authorities.

PART VII

THE HEALTH OF THE SCHOOL CHILD

**The Annual Report of the Principal School
Medical Officer**

including

**The Report of the Principal School Dental
Officer**

and

**The Report of the School Medical Officer to
the Keighley Excepted District**

THE HEALTH OF THE SCHOOL CHILD

(Being the 53rd Annual Report of the Principal School Medical Officer)

Introduction:

One of the major changes in the School Health Service has been the introduction, in two areas, of a scheme to examine the children in the intermediate age group (7-11 years) on a non-routine basis.

Dr. Withnell, Divisional Medical Officer of the Morley area, reports as follows:—

“ The non-routine scheme was inaugurated in January, 1960 by meeting the head teachers of all those schools which contained children aged 7—11 years inclusive. The scheme was explained to the teachers and the Divisional Education Officers were also invited to attend these meetings so that the co-operation of the teaching profession was obtained. The scheme was planned to operate in the first instance for one year but it has now been extended to July, 1961.

Questionnaires were first sent to the parents of all children who were in their first year in the Junior School. On completion these forms were scrutinised by the medical staff and from the information obtained the doctors decided which children should be examined. The school medical cards of these selected children together with the school medical records of children in the same age group who had been referred by the teachers were then scrutinised and these children and their parents were invited to see the School Medical Officer.

A full report of this scheme will be available later but the following broad trends are already evident.

(1) A larger number of backward children and a larger number of children suffering from speech defects have been detected under the new scheme. This is undoubtedly due to a closer co-operation with teachers.

(2) A larger number of children with defective vision and with defective hearing have also been detected.

(3) The reaction of the teachers to the scheme has continued, on the whole, to be favourable. They now feel they are playing a more important role in the School Health Service and they also find that disruption of school routine is less under the new scheme.

(4) The parents have co-operated very well in the completion of questionnaires. Very few forms seem to have been completed carelessly or inadequately and all such children were, of course, examined.

(5) The non-routine scheme requires more, not less, medical time. It is absolutely necessary that every school should be visited each term.”

The extent to which serious defects in children are being missed under the new scheme can never be known with certainty but an indication can be obtained at the end of the trial period by comparing the incidence of different defects discovered with those discovered during a similar period under the old method. This assessment will be attempted in 1961.

In my last report I indicated the need to assess hearing loss in children as early as possible. To this end twenty-four Health Visitors attended a special course in August, 1960 arranged by the Department of the Deaf, Manchester University, and twenty-two received the certificates. Although the course was held in August, 1960 the final test for Health Visitors was held in November,

1960, when Dr. I. G. Taylor of Manchester University came to see all the Health Visitors to ensure that they were competent to do this work. It must be emphasised here that it requires two specially trained Health Visitors to assess any hearing loss in a young child and it has therefore been arranged that a further twenty-four Health Visitors will be trained in 1961.

Those Health Visitors who have been trained have carried out tests on children as follows:—

<i>0—1 year</i>	<i>1—2 years</i>	<i>2—5 years</i>
232	129	136

Of the children tested, twenty-two were referred to Audiology Clinics and four to E.N.T. Clinics (three had tonsillectomy performed).

I regret to state that there has been some contraction of the Child Guidance Service due to the departure for the United States of America of Dr. Stephanie M. Leese. The Leeds Regional Hospital Board have been unable to find a replacement for Dr. Leese so it was arranged between Leeds and Sheffield Regional Hospital Boards that Dr. Crowley should attend the Pontefract Clinic on one half-day per week. He has also visited Nortonthorpe Hostel once per week. In the other clinic attended by Dr. Leese at Mirfield, Mr. Pickles, the Clinical Psychologist, has continued to see cases, but this is not entirely satisfactory.

The medical staffing has remained fairly stable but it is becoming increasingly difficult to obtain medical staff of the calibre one would desire. The heavy programmes of immunisation and vaccination have again been successfully carried out although the number protected against poliomyelitis has dropped. In 1958 there were 99 cases of Paralytic Poliomyelitis in the West Riding; in 1959 the number of cases of Paralytic Poliomyelitis was 12 and in 1960 it dropped to 6.

As will be noted, there has been a decrease in the number of routine school medical inspections due to the introduction in two areas of the County of the experimental scheme of non-routine school medical examination.

The Mental Health Act, 1959 has made some slight changes in procedure in the ascertainment of children under Section 57 of the Education Act, but this is explained in detail under the section dealing with the educationally sub-normal child.

A new project was initiated by the Education Committee this year by the appointment to the Harrogate Child Guidance Clinic of a teacher to help children who are retarded educationally and emotionally unstable. Details of the work carried out by Miss Blackburn appear in the section dealing with the Harrogate Child Guidance Clinic. A similar appointment at the Swinton Child Guidance Clinic is envisaged but unfortunately so far no suitable candidate has been available.

It gives me great pleasure to record once again my appreciation of the full co-operation given by the Chief Education Officer and his staff and by the school teachers who accept the many necessary interruptions to their class work in a kindly manner.

The Medical Inspection of School Children:

The number of pupils on the registers is as follows:—

						<i>Boys</i>	<i>Girls</i>	Total
Nursery	...	...	...	...	...	299	246	545
Primary (County)	...	...	...	...	...	61,245	57,858	119,103
Primary (Voluntary)	...	...	...	...	...	21,053	19,784	40,837
Secondary Modern (County)	...	...	...	...	...	34,095	31,110	65,205
Secondary Modern (Voluntary)	...	...	...	...	...	1,498	1,672	3,170
Secondary Grammar	...	...	...	...	...	13,363	13,419	26,782
Secondary Technical	...	...	...	...	...	1,406	1,311	2,717
Comprehensive	...	...	...	...	...	3,219	3,204	6,423
Special Schools	...	...	...	...	...	499	374	873
						<hr/> 136,677	<hr/> 128,978	<hr/> 265,655

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A.—Periodic Medical Inspections

Age groups inspected (by year of birth) and number of pupils examined in each:—

<i>Year of Birth</i>					
1956 and later	...	...	...	...	1,766
1955	...	...	...	...	11,745
1954	...	...	...	...	7,472
1953	...	...	...	...	4,029
1952	...	...	...	...	10,219
1951	...	...	...	...	4,806
1950	...	...	...	...	2,795
1949	...	...	...	...	9,299
1948	...	...	...	...	7,810
1947	...	...	...	...	2,922
1946	...	...	...	...	7,116
1945 and earlier	...	...	...	...	13,651
Total					<hr/> 83,630

B.—Other Inspections

Number of Special Inspections	...	18,311
Number of Re-Inspections	...	9,818
Total	...	<hr/> 28,129

C.—Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (Year of Birth)	For defective vision excluding squint	For any of the other conditions recorded in Table III	Total individual pupils
1956 and later	39	173	209
1955	308	1,189	1,412
1954	200	642	805
1953	157	337	469
1952	493	778	1,211
1951	211	339	527
1950	145	311	449
1949	443	655	1,078
1948	404	568	929
1947	147	198	329
1946	269	482	719
1945 and earlier	706	926	1,553
Total	3,522	6,598	9,690

D.—Classification of the Physical Condition of Pupils inspected in the Age Groups recorded in Table I.A

Age groups inspected (Year of Birth)	Number of pupils inspected	Satisfactory		Unsatisfactory	
		No.	% of Column 2	No.	% of Column 2
1956 and later ...	1,766	1,746	98·87	20	1·13
1955 ...	11,745	11,643	99·13	102	0·87
1954 ...	7,472	7,377	98·73	95	1·27
1953 ...	4,029	3,993	99·11	36	0·89
1952 ...	10,219	10,080	98·64	139	1·36
1951 ...	4,806	4,771	99·27	35	0·73
1950 ...	2,795	2,766	98·96	29	1·04
1949 ...	9,299	9,224	99·19	75	0·81
1948 ...	7,810	7,750	99·23	60	0·77
1947 ...	2,922	2,902	99·32	20	0·68
1946 ...	7,116	7,084	99·55	32	0·45
1945 and earlier...	13,651	13,556	99·30	95	0·70
Total ...	83,630	82,892	99·12	738	0·88

TABLE II

INFESTATION WITH VERMIN

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	467,937
(ii)	Total number of <i>individual</i> pupils found to be infested ...	10,341
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ...	172
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944) ...	17

TABLE III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1960

NOTE.—All defects noted at medical inspection as requiring treatment are included in this table, whether or not this treatment was begun before the date of the inspection

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS						SPECIAL INSPECTIONS	
		Entrants		Leavers		TOTAL (including all other periodic age groups inspected)		Requiring treatment	Requiring observation
		Requiring treatment	Requiring observation	Requiring treatment	Requiring observation	Requiring treatment	Requiring observation		
4	Skin	208	315	372	288	1,045	1,185	508	367
5	Eyes—	589	1,129	900	1,810	3,546	6,831	1,124	2,712
	a. Vision	290	348	31	105	483	1,001	114	206
	b. Squint	50	63	37	53	190	262	95	64
6	Ears—	48	198	35	98	186	669	116	271
	a. Hearing	76	236	60	91	233	679	89	215
	b. Otitis Media	37	42	72	37	228	205	72	66
7	c. Other	526	1,514	110	330	1,141	3,416	378	1,257
8	Nose and Throat	148	365	15	47	368	695	313	325
9	Speech	33	657	7	78	76	1,279	27	340
10	Lymphatic Glands	40	343	38	184	143	1,024	33	360
11	Heart	130	602	35	177	314	1,567	141	512
12	Lungs								
	Developmental—								
	a. Hernia	31	66	2	7	57	155	17	43
	b. Other	39	399	20	90	170	1,174	49	295
13	Orthopaedic—								
	a. Posture	32	90	43	195	184	688	53	139
	b. Feet	215	444	182	447	762	1,751	242	536
	c. Other	125	371	72	269	350	1,305	169	431
14	Nervous System—								
	a. Epilepsy	11	28	8	32	45	138	24	58
	b. Other	49	136	40	53	193	441	33	161
15	Psychological—								
	a. Development	11	115	4	86	74	532	388	322
	b. Stability	29	219	10	85	96	720	74	266
16	Abdomen...	19	71	8	20	52	214	18	53
17	Other	165	189	214	118	814	619	679	378

TABLE IV
TREATMENT OF PUPILS

Notes

The figures given under this heading include:—

- (i) cases treated or under treatment during the year by members of the Authority's own staff;
- (ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board; and
- (iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

Group 1. Eye Disease, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	1,499
Errors of refraction (including squint)	19,152
Total ...	20,651
Number of pupils for whom spectacles were prescribed ...	10,029

Group 2. Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been treated
Received operative treatment:—	
(a) for diseases of the ear	18
(b) for adenoids and chronic tonsillitis	1,235
(c) for other nose and throat conditions	82
Received other forms of treatment	715
Total ...	2,050

Total number of pupils in schools who are known to have been provided with hearing aids:—

(a) in 1960	24
(b) in previous years	159

Group 3. Orthopædic and Postural Defects

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments	1,046
(b) Pupils treated at school for postural defects ...	7
Total ...	1,053

Group 4. Diseases of the Skin (excluding uncleanness for which see Table II)

Ringworm—(a) Scalp	4
(b) Body	46
Scabies	137
Impetigo	509
Other skin diseases	3,283
Total ...	3,979

Group 5. Child Guidance Treatment

Number of pupils treated at Child Guidance clinics under arrangements made by the Authority	637
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Group 6. Speech Therapy

Number of pupils treated by Speech Therapists under arrangements made by the Authority	1,732
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Group 7. Other Treatment Given

(a) Number of cases of miscellaneous minor ailments treated by the Authority	15,308
(b) Pupils who received convalescent treatment under School Health Service arrangements ...	99
(c) Pupils who received B.C.G. vaccination ...	11,997
(d) Other:—	
1. Ultra Violet Light Treatment	813
2. Chiropody	582
Total (a)—(d) ...	<u>28,799</u>

Care of the Handicapped Child:

The ascertainment of any type of handicap in childhood rests entirely with the School Medical Officer and only he can recommend to the Local Education Authority any form of special educational treatment. This necessitates not only a very full and up-to-date knowledge of medical conditions but also very complete information as to the provisions of the Education Act, 1944 and the facilities available. This involves close liaison with the parent and the family doctor.

In order to keep the School Medical Officer up-to-date with the advances in modern medicine, full advantage is taken of the post graduate courses available, the Committee having generously approved the applications for leave of absence and payment of expenses to enable medical officers to attend such courses.

The number of new ascertainments and re-examinations undertaken during 1960 was 1,813 compared with 1,697 the previous year, details are as follows:—

Category	No. of examinations and re-examinations
Educationally sub-normal	1,148
Physically handicapped	298
Delicate	171
Deaf	40
Partially deaf	19
Epileptic	27
Speech (requiring special school)	—
Maladjusted (requiring hostel or special school)	53
Blind	9
Partially sighted	9
Double defect	39
Total ...	<u>1,813</u>

The following table gives details of handicapped pupils and placings in special schools and hostels during the year, and particulars of the number of children a residence in special schools at the end of the year:—

Category	New Ascertainments	New Placings in Special Schools	Total No. attending Special Schools		No. Boarded in Homes or Hostels	No. Attending Independent Schools	No. Awaiting Placement in Special Schools	No. receiving Home Tuition
			Day	Board- ing				
Blind	7	1	—	41	—	—	9	—
Partially Sighted	6	14	16	40	—	—	5	—
Deaf	19	23	23	136	—	—	13	—
Partially Deaf	12	5	12	27	—	—	1	—
Delicate	53	64	47	84	1	—	33	3
*Physically Handicapped	36	22	27	87	—	10	29	46
Educationally Sub-normal	304	158	506	275	—	9	478	—
Maladjusted	31	18	—	9	28	—	18	2
Epileptic	9	13	—	20	—	—	3	—
Speech Defects	2	—	1	—	—	—	3	—
Totals	479	318	632	719	29	19	592	51

Excluding children sent to or awaiting places in hospital schools. At the end of the year there were 130 children on the registers of hospital special schools.

THE PHYSICALLY HANDICAPPED CHILD:

Cerebral palsy continues to be the main cause of physical defect in children.

Particulars relating to educable cerebral palsied children in the County are given below. The figures include children of pre-school age.

Total No. of educable Spastics	No. accom- modated in Special Schools	No. attending Ordinary Schools		No. receiving Home Tuition	No. receiving no Education
		Satisfactorily	Needing placement in Special Schools		
203	94	66	35	5	3

The 94 children in special schools are accommodated as follows:—

Condoover Hall Special School, Shrewsbury	..	..	..	..	..	1
St. Vincent's Special School, Pinner ..	..	..	..	..	..	1
Tudor Grange Special School, Warwick	..	..	..	..	..	1
Heritage Craft Schools, Chailey	..	..	..	..	..	1
Adela Shaw Orthopædic Hospital, Kirkby Moorside	..	..	..	..	..	1
Royd Edge School for Educationally Sub-normal Children	..	..	..	..	..	1
Holly Bank Special School, Huddersfield ..	..	..	..	..	..	20
Exhall Grange, Coventry	..	..	..	..	..	1
Bradstock Lockett Hospital School, Southport	..	..	..	..	..	2
Hesley Hall Special School, Tickhill	..	..	..	..	..	10
Camphill Rudolf Steiner Special School, Thornbury Park	..	..	..	..	..	2
Wilfred Pickles' School, Tixover Grange, Duddington	..	..	..	..	..	6
Hinwick Hall School, Wellingborough	..	..	..	..	..	1
St. Rose's R.C. Special School, Stroud	..	..	..	..	..	2
Baliol School for Educationally Sub-normal Pupils	..	..	..	..	..	1
Etton Pasture School for Educationally Sub-normal Pupils	..	..	..	..	..	1

Moorlands Open Air School, Dewsbury	1
Bethesda Home, Salford	5
National Children's Home, Chipping Norton	1
Rob Roy Special School, Oakham	1
Victoria Home Special School, Bournemouth	1
Stile Open Air School, Todmorden	3
Welburn Hall Special School, Kirkby Moorside	2
Wombwell Day School for Educationally Sub-normal Pupils	1
St. Margaret's School, Croydon	1
Lister Lane Day Special School, Bradford	4
Shipley Day School for Educationally Sub-normal Pupils	1
Lingfield School for Epileptics	2
Irton Hall Special School, Cumberland	4
Chaucer Street Special School, Oldham	1
Halliwick Cripples Special School, Winchmore Hill, Middlesex	1
Hilton Grange Special School, Bramhope	1
Odsal House Day Special School, Bradford	1
Hartshead Moor Day Special School for Educationally Sub-normal Pupils	1
Hawksworth Hall, Guiseley	1
Talbot House Special School, Glossop	1
Thomas Delarue Special School, Kent	1
Larchfield School, Harrogate	1
Ian Tetley Memorial Home, Harrogate	1
Field Heath House Special School, Hillingdon	1
Besford Court R.C. Special School	1
Scotfield Special School, Oldham	2
Mayfield Day Special School, Sheffield	1

THE DELICATE CHILD:

As indicated in previous reports, there has been a steady decline in the numbers of children who could be ascertained as delicate. This is true of the country as a whole and is not only applicable to the West Riding administrative area. The number of new ascertainties during 1960 was 53 compared with 72 in the previous year. The number attending special schools during the past year has fallen slightly and in the Authority's special school at Netherside Hall there has been a decreased attendance due to staffing difficulties.

The type of handicap admitted to the Authority's two Special Boarding Open Air Schools remains the same, namely either Bronchitis, Bronchiectasis or Asthma, with an occasional compassionate admission where home conditions are bad.

Dr. Harvey, part-time pædiatrician to the West Riding, visits Ingleborough Hall Residential Open Air School for Junior Delicate Children and Netherside Residential Open Air School for Senior Boys twice yearly. His help and advice are greatly appreciated by both doctors and teachers.

THE BLIND AND PARTIALLY SIGHTED CHILD:

Children who may be suffering from blindness or partial sight are examined by an ophthalmologist of consultant status. If, in addition, there is any reason to suspect mental retardation the child is also examined by a school medical officer and a clinical psychologist before a final recommendation for special educational treatment is made.

THE DEAF AND PARTIALLY DEAF CHILD:

Thirty-one children were ascertained as deaf or partially deaf during 1960 as compared with 20 in 1959. At the end of the year 35 children were attending special day schools and 163 were accommodated in boarding special schools, 14 children awaiting placement.

As already stated in my introduction it is of the utmost importance that all cases of suspected deafness should be investigated at as early an age as possible. Twenty-four health visitors have attended a course arranged by the Department of the Deaf, Manchester University, but I am of the opinion that facilities for examining children with suspected hearing loss should be available outside the hospitals. To that end I have made arrangements for two Audiology Clinics to be started early in 1961. One will be situated in the Horsforth area to serve the northern half of the County; and the one for the southern half of the county will function in the Yorkshire Residential School for the Deaf, Doncaster, by courtesy of the Headmaster, Mr. Greenaway. Each Clinic will be staffed by a Consultant Otologist, a Divisional Medical Officer, a teacher of the deaf and a Clinical Psychologist. As no one can measure the size of this problem in advance, it is not yet known whether a monthly meeting of one half-day will be adequate or not.

By the courtesy of the Committee the number of Pure Tone Audiometers has increased early in the year from four to seven and in 1961 there will be nine available for use throughout the county. It was hoped that nine might be sufficient but it now appears that we might require more, once the use of these machines becomes universal.

Reports from areas where Pure Tone Audiometers have been used indicate that no cases of gross deafness has been discovered, which is as it should be but many minor degrees of hearing loss have been found. In most areas a start to this problem was made by a letter to all head teachers asking for the names of children who might be hard of hearing or of children who were failing to profit from education in school for no apparent reason.

When these lists were obtained Audiology sessions were arranged by the Assistant County Medical Officers using as quiet a room as could be obtained in a neighbouring school or clinic. Examination of these children revealed a bewildering variety of hearing loss, ranging from a temporary loss due to a catarrhal condition, a hearing loss which might be unilateral or hearing loss which only required favourable placing in the front of the class, to conditions which required referral to E.N.T. surgeons for either surgical treatment or the recommendation for a hearing aid. It has emerged that the minor ailment clinics which largely fell into disuse following the National Health Service Act, 1946 will require to be organised again for the follow-up and if necessary for the treatment of otitis media, wax in ears or any other minor condition of a temporary nature which is resulting in hearing loss.

Sweep testing of hearing loss has not been undertaken as a routine measure throughout the county, but children in the groups known to be "at risk" have been investigated—these include:—

- (i) children with a family history of deafness,
- (ii) children with otorrhœa,
- (iii) children with athetosis,
- (iv) children who had perinatal abnormalities, e.g. asphyxia, Rhesus incompatibility especially Kernicterus,
- (v) history of German measles in first two months of pregnancy,
- (vi) prematurity,
- (vii) children who have had a severe illness, e.g. meningitis or any who have been treated with streptomycin.

In addition to the above, children with speech defects and those who are failing to make progress educationally in school are investigated.

In the Skipton area three schools, with a total of 637 children, have been surveyed. Thirty children were selected and it was found that hearing was normal in 21, slight deafness was present in five, moderate deafness in three and severe deafness in one. The slight and moderate degrees of deafness were referred for treatment and the case of severe deafness was referred to a consultant and subsequently received a hearing aid.

The audiometer has also been used at Netherside Hall Open Air School for Senior Boys where two boys were found to be deaf—one severely. Both have been referred to a consultant.

In the Rotherham area spasmodic attempts have been made, in the past, to test the hearing of children by whispered speech, but this time-consuming method gave results which were not encouraging. The use of the Pure Tone Audiometer in the area has proved to be of tremendous value in revealing children with partial deafness. The Head Teachers of all Junior and Senior Schools, 29 in all, were asked to send in lists of children with hearing difficulties and 244 names were obtained. Audiology sessions were then arranged, twelve children attending each session. As a result of this investigation it has been decided to include audiometric testing as part of the annual school medical inspections in this area. Head Teachers will be asked for lists of children with hearing defects and special sessions for hearing tests will be arranged during the inspections so that parents may attend.

There has been a change in the policy of the Ministry of Education regarding the education of the deaf and partially deaf. Previously these two categories of handicapped children were educated together but now it has been decided that partially deaf children must be educated separately from deaf children. This will no doubt encourage the use of speech amongst the partially deaf.

Elmete Hall School, Leeds has become a school for the partially deaf, while the Yorkshire Residential School, Doncaster and the Maud Maxfield School, Sheffield are both listed as schools for the education of deaf children.

THE EPILEPTIC CHILD:

The increased medical knowledge of epilepsy and the availability of drugs which control the seizures has brought a lessening in the demand for places in special schools for epileptic children. It is now possible to retain in ordinary schools many of the children who, previously, have been cases for a residential establishment.

THE EDUCATIONALLY SUB-NORMAL CHILD:

The educationally sub-normal child belongs to the largest category of handicapped child, and doctors carrying out the ascertainment of these children must have previously attended a special three week course of training run by the National Association for Mental Health in London.

The ascertainment of educationally sub-normal children was carried out under Section 57 of the Education Act, 1944 but Section 11 of the Mental Health Act, 1959 now amends this particular section of the Education Act. The changes are set out in the Ministry of Education Circular 12/60, the Ministry of Health Circular 22/60 and the Memo. H.M.(60) issued to Regional Hospital Boards.

The following aspects of the new Section 57 of the Education Act merit special attention. Where a change of procedure is indicated, the new procedure, as agreed with representatives of the Education Department, is outlined herein.

Education Act. Section 57 (As amended).

Para. 4 of
Circular 12/60.

The phrase "unsuitable for education at school" replaces the words "incapable of receiving education at school." The omission of the words "if it appears to the Local Education Authority" and the substitution of "it shall be the duty of the Local Education Authority" eliminates the necessity to obtain Committee approval before ascertaining a child under this section. The reference to the "small number of children who are capable of profiting from education but who are not satisfactorily placed in an ordinary or special school" relates to those formerly dealt with under the old Section 57(4).

Paras. 6/7/8
of Circular
12/60.

Notice of Examination etc. Section 57(1), 57(2) and 57(3).

The circular suggests that the officer serving the notice should not be the Medical Officer conducting the examination. It has been agreed, therefore, that the notice be sent by the Divisional Education Officer who would arrange for it to be served personally by an Education Welfare Officer, together with the "informal and friendly letter" mentioned in paragraph 7 of the circular. To avoid a duplication of visits, the time and place of the examination would be notified at the same time. It will, therefore, be necessary for Divisional Medical Officers to give the Divisional Education Officer the name and address of children for examination, and the time and place, in reasonable time for the notice to be served. The Chief Education Officer proposes to brief Education Welfare Officers for this particular duty. Form H.P.6 will be revised for this purpose. Form H.P.5 for examination under Section 34 of the Education Act, will continue to be issued by the Divisional Medical Officer as hitherto.

Paras. 11/12/13
of Circular
12/60.

Conduct of the Examination and Decision by the Authority. Section 57(4).

The examining Medical Officer should make it clear to the parent that his findings will be a *recommendation only* and that the final decision rests with the Local Education Authority. He should put the parent fully into the picture as to the action likely to follow if the child is found to be unsuitable for education at school. Sub-Section 57(4) of the Amended Section of the Education Act, 1944, replaces the old 57(3).

Para. 15 of
Circular 12/60.

Informing parents of Local Health Authority arrangements. Section 57(6).

In communicating a decision to the parent, the Chief Education Officer will wish to give as much information as possible about the arrangements which will be made by the Local Health Authority. It will, therefore, be necessary to give on Form 2 H.P. specific details about the provision (or lack of provision) of alternative facilities for the child in question. Divisional Medical Officers are asked to ensure that this information is entered on the form before it is sent to the central office. The

decision will be communicated to the parent by a letter which will be delivered personally by the Mental Welfare Officer (as is the present practice).

*Paras. 16/17
of Circular
12/60.*

Reviews. Section 57(A).

Paragraph 16 gives details of the right of a parent to request the review of a decision. It should be mentioned here that in the few cases which, in the past, have been subject to a reversal of a decision, the child has not made the progress expected. Very careful consideration should, therefore, be given before recommending the cancellation of a decision.

*Paras. 21/22
of Circular
12/60.*

Avoidance of Second Examination—Section 57B.(2) and (3).

In all obvious cases, action should be initiated under the appropriate Section (i.e. 34 or 57). In cases of doubt it would be safer if the initial action were taken under Section 57, even if the ultimate recommendation is in accordance with the provision of Section 34.

*Paras. 23/24
of Circular
12/60.*

Attendance at School.

Although it is possible for the Local Health Authority to provide help for a child *obviously unsuitable* for education at school, without a decision under Section 57, it is administratively desirable that Section 57 be used in all cases where the child is five or over. In urgent cases a child could, of course, be placed in a Training Centre pending Section 57 action. If children under five are dealt with in this way by the Local Health Authority, they should become subject to a decision under Section 57 in good time for a decision to be reached when they become of school age.

*Paras. 25/6/7
of Circular
12/60.*

Care of School Leavers.

The term "care and guidance" replaces the word "supervision", as used in the current Section 57(5) of the Act. There is no equivalent Section in the Amendment. To determine the cases needing "care and guidance", the Chief Education Officer will pass to the County Medical Officer files for all educationally sub-normal children due to leave school. These will be passed to Divisional Medical Officers for their recommendation and it should be remembered that the new term embraces a wider range of children than did the former term, and that emotional stability is as important a factor as the I.Q. in determining whether or not a child requires "care and guidance."

*Paras. 4—7
of Ministry
of Health
Circular 22/60.*

Power to compel attendance at Training Centres.

Paragraphs 4—7 of Ministry of Health Circular 22/60 enlarge on the power given to Authorities by Sections 12 and 13 of the Mental Health Act, to compel the attendance at training centres of children recorded as unsuitable for education at school. Consideration is being given to the production of the "appropriate notice" to be served on parents as mentioned

in paragraph 5. Where a Divisional Medical Officer wishes to initiate action to compel the attendance of a particular child of school age, full details must be submitted to the County Medical Officer by minute. The report should cover all the points mentioned in paragraphs 4—7 of the circular. The case will then be submitted to the Mental Health Sub-Committee for a decision as to whether a statutory notice should be served. It is anticipated that any such notice will be served by the Clerk of the County Council. The Divisional Medical Officer will, of course, subsequently ascertain whether there has been compliance with the notice and will report accordingly to the County Medical Officer.

During the year 122 children have been reported to the Local Health Authority as “unsuitable for education in school” and 79 children as requiring “care and guidance” have been reported informally to the Mental Health Section of the Local Authority.

EMPLOYABILITY OF EDUCATIONALLY SUB-NORMAL SCHOOL LEAVERS:

The following summary has been compiled from the Youth Employment Officer's reports on educationally sub-normal school leavers in the case of 30 boys who had received special educational treatment in the Authority's Special School, Baliol, Sedbergh.

I.Q. Range	Number of Cases	Reports on Employment	
		Satisfactory	Unsatisfactory
70-79	14	14	—
65-69	4	2	2
60-64	7	5	2
55-59	5	3	2
TOTAL	30	24	6

Although the total number is small it does indicate that the overall picture of the educationally sub-normal child is hopeful regarding satisfactory employment. Where an unsatisfactory result has been obtained other factors besides the educational sub-normality must be considered, particularly the emotional stability not only of the child himself but also of his home and background.

The report from Baliol Special School also indicated an exceedingly wide range of work undertaken by these boys, from general labourer to trainee in a large number of different kinds of works such as bleach works, cutlery works, textiles, apprentice joiner, constructional engineering and farming.

CHILDREN WITH SPEECH DEFECTS:

The Authority has an establishment of 13 Speech Therapists which is to be increased to 18 next year, so that when the medical Divisions ultimately reach the number of 18, each Division will have a Speech Therapist. During the year we have had eleven full-time and two part-time Speech Therapists but it is hoped

next year to reach the full complement as there are seven being trained under the West Riding County Council scheme who should complete their training in July, 1961.

Children requiring Speech Therapy are usually referred to the Speech Therapist by the School Medical Officer and with the increase in the number of Pure Tone Audiometers it is hoped that every child suffering from a speech defect should have an audiometric test as soon as possible. Each Speech Therapist has the use of a tape recorder for recording defects of speech at the initial interview and later playing the tape back to the child to show how much progress has been made.

THE MALADJUSTED CHILD:

I regret that 1960 has not been a progressive year in the field of Child Guidance. Dr. Leese who attended the Mirfield and Pontefract Clinics and visited Nortonthorpe Hostel weekly left the service in August, 1960 to go to the United States of America. Since then the Mirfield Clinic has been carried on single-handed by Mr. Pickles, Clinical Psychologist.

The Pontefract Clinic obtained the services of Dr. Crowley, Consultant Psychiatrist, for one half-day per week by a temporary arrangement between the Sheffield and Leeds Regional Hospital Boards, but as Dr. Crowley points out in his report:—

“ Pontefract is a very active Clinic serving six Divisions which would need the attendance of a Psychiatrist for four sessions per week at least. It has been possible with the strenuous efforts of Mr. Coulson (Psychiatric Social Worker) and Mr. Pickles (Clinical Psychologist) to keep pace—the work done, however, is mainly diagnostic and there is little time for treatment.

School refusals, children in urgent need of placement in residential schools or hostels, and delinquents requiring psychiatric reports for the Courts, form the bulk of the urgent referrals and have to be dealt with expeditiously. I have found the work here very interesting as all the children seen to present much more serious and acute problems compared with other clinics. Much more time should be given to all these cases to ensure adequate investigation and treatment.”

The Harrogate Clinic was fortunate in acquiring the services of Dr. Elizabeth Gore in May, 1960 and she reports as follows:—

“ When I started the Harrogate Child Guidance Clinic in May, 1960 I found a Clinic which had clearly become an important and integral part of the Health and Welfare Services of the town and surrounding districts which it serves. For this I must thank my predecessor, Dr. Kahn and also Mrs. Nursten and Mr. Pickles who had kept all the contacts going and also carried on smoothly and competently during the period when the Clinic was without a Psychiatrist.

We have continued the practice of being “ at home ” during the lunch hour on Thursdays and some of our visitors have almost become part of our Clinic team—the most regular has been Dr. Schofield, Senior Assistant County Medical Officer, with whom we have been able to discuss many mutual problems. We have also kept in regular contact with Miss Sedgwick, the Assistant Children's Officer, the Probation Officer and Miss Wallace, the Senior Mental Welfare Officer.

In September we had a visit from Mr. T. P. Garcia from the Philippines who came to us as part of a tour of Child Guidance Services in this Country. Mr. Garcia's comment on leaving is worth recording. He said, ‘ what impresses me is the way you try to reach all children.’

Miss Blackburn commenced her remedial teaching in the Clinic in January, 1960. Her work has grown during the year and she is now dealing on an average with 12 children. All of Miss Blackburn's children have been selected by Mr. Pickles or myself as requiring special remedial help. Most are also coming for psychiatric treatment but some benefit sufficiently from individual tuition or from participation in a small teaching group. Several of the children present severe educational problems; for example a girl aged 14 years who is refusing to attend school; a boy aged 11 years who is retarded in all basic subjects and virtually a non-reader. Miss Blackburn has kept a close contact with the schools and teachers concerned, and has begun a follow-up of children who attended and are now discharged."

The Skipton and Shipley Clinics—these are attended by Dr. W. M. Burbury, Consultant Psychiatrist, and occasionally by Mr. Pickles, Clinical Psychologist. Unfortunately there is no Psychiatric Social Worker for the work of these two Clinics. Dr. Burbury reports as follows:—

"The Clinics at Skipton and Shipley, the latter covering the Divisions of Keighley and Horsforth as well as Shipley, have continued to function as last year. This is not a satisfactory position as it entails an attempt to cope with a child population of 38,686 on four sessions per week. This is, of course, a quite unreal proposition and the result is now a deadlock where no further cases, no matter what the urgency, can be taken for treatment."

Swinton, Ecclesfield and Barnsley Clinics. Dr. Orme, Consultant Psychiatrist to the above Clinics, reports as follows:—

"1960 has been an important year with the establishment of permanent quarters for the Child Guidance Service in these areas at Rock House, Swinton. Now that alterations are complete there is adequate accommodation for Psychiatric Social Worker, Psychologist and Psychiatrist, for the Secretary and for parents and children waiting to be seen. A room permanently equipped for play therapy and for the observation of children under informal conditions is a great benefit, and it is very useful for the Psychiatric Social Worker and Psychologist to have rooms which they know will always be available for interviews even when the clinic is not in normal session. It is hoped that a Teacher will soon be appointed so that a remedial class can be formed for children who are needing special help in one way or another because of their emotional problems (as has been done at Harrogate).

In February Mr. Valentine, Clinical Psychologist, joined the team and has done very valuable work in establishing close contact with schools particularly around the Swinton area, and in visiting schools in more outlying districts with which there would not have been any contact otherwise. This is particularly true for cases in Division 22 from Penistone and Stocksbridge areas, as it is very difficult for the children to get to the clinic at Ecclesfield. Not only has Mr. Valentine been visiting schools, but also the homes of many of the cases and has been taking an active part in the treatment programme. He has made a number of special investigations for School Medical Officers and for Dr. Harvey, the Pædiatrician, of children with handicaps which interfere with the usual processes of assessment.

Children who have been sent to special schools have been followed up during the holidays and attempts made to co-ordinate any home treatment necessary with that being carried on at their schools. Discussion of problems of children's behaviour both before referral and as part of the treatment programme have been held with School Medical Officers, Child Care Officers and Probation Officers. There has been close co-operation in some cases with General Practitioners and Pædiatricians."

Woodlands Child Guidance Clinic. Dr. Crowley reports:—

"This Clinic seemed to come to life immediately. The premises and location are good and convenient to Doncaster. The many nearby schools and doctors availed themselves of the service quickly and it was easy to have contact with them. I have received great help from the Divisional Medical Officers, the School Medical Officers, experienced secretaries and enthusiastic Health Visitors. Mr. Valentine, Clinical Psychologist, joined me early in 1960 and Mrs. Bruce, an experienced Psychiatric Social Worker, in the Autumn.

There was much preparatory ground work to be done, talks to school teachers, welfare workers, probation officers, contacts with General Practitioners and most important with the local hospitals. It is not easy to explain to people the exact function of the Child Guidance Clinic or the role of the psychiatrist, psychologist etc. but they are given some idea about the type of child to be referred and how to do so. It will inevitably take some time before a mutual understanding is built up.

It became obvious that the efficiency of the child psychiatric service is inversely related to the distance from the patient's home. One or two visits were all that we could expect from a family that took up to four hours to reach us. The Psychiatric Social Worker is essential in these scattered areas as well as the Health Visitors. Attempts have been made to move the clinic around to reach some of the outlying areas. Personal contacts and ingenuity are often necessary to overcome some of these bottle-necks.

Close co-operation with the Children's Department of the Doncaster Royal Infirmary has been very useful. Many children are referred to the Pædiatrician first and especially the young child or one with any suggestion of physical illness. Often it is very difficult to draw a line between a physical illness and the psychological sequelæ. Epilepsy, asthma, endocrine disorders are examples of the necessity of a joint approach by physician and psychiatrist.

This combined effort in the hospital out-patient department of a central and well known hospital has allowed me to see children at a very early stage of maladjustment or emotional disturbance when it is so much easier to treat them. Incipient school phobia can be dealt with before the child misses even one day of school. A preliminary assessment can be carried out before the child is referred to the clinic. The hospital out-patients department is particularly useful for seeing fathers or adolescents who could not attend Woodlands during the day. It also helps to overcome the geographical difficulties because of its central location. It has been very helpful in the rapid establishment of the Woodlands Clinic.

The probation officers in the Doncaster area have been very co-operative and as their work and ours is closely interwoven in the cases of younger children and problem families the close liaison has been mutually beneficial.

A satisfactory aspect of the Woodlands Clinic is the wide range of children seen from infants to young adults, with all kinds of complaints."

Dalton Child Guidance Clinic. Dr. Crowley reports as follows:—

"This clinic has been rather disappointing, in the numbers of new cases referred, the level of attendance and the type of case. The geography of the division has much to do with this. Some parents find it almost impossible to get to the clinic at Dalton. The situation is not good and steps have been taken to move the clinic to Maltby which is more of a centre of the area, as well as of population and communication. Some cases where the parents are particularly worried have probably been going to Sheffield.

Talks given to the school teachers and the Health Visitors have helped but there are still many families obviously in need of psychiatric treatment who refuse to co-operate.

A clinic is held one day a month in Dinnington and the same could be done elsewhere if there was a sufficient number in that area.

The use of a Psychiatric Social Worker is essential in a scattered division, such as this, and Mrs. Bruce has done much to contact some of these outlying or unco-operative families. Mr. Valentine has been visiting the various schools to deal with educational problems as well as in the clinic itself. There is a great need for remedial teaching and solving the problem of the E.S.N. children in ordinary schools. A close liaison with the Probation Officers has been of mutual benefit, especially in dealing with some of the problem families."

The Clinical Psychologists.

Mr. Pickles has been in the service of the West Riding since early 1956 and in February, 1960 a second Clinical Psychologist, Mr. H. B. Valentine, took up his appointment. It was arranged that Mr. Pickles should attend the Child Guidance Clinics in the northern half of the West Riding administrative area and Mr. Valentine the Clinics in the southern half.

Owing to staff changes during the year at the Harrogate Clinic, which was without a Psychiatrist from January to May, and at the Mirfield Clinic which has had no Psychiatrist since September, Mr. Pickles has had a wider degree of responsibility.

In the case of both Psychologists a number of children with a wide range of physical and sensory handicaps have been referred for psychological assessment, only a proportion of whom have been seen in the Child Guidance Clinics; in many cases it has been necessary to see these children in their homes, at divisional clinics or occasionally in their schools.

Mr. Pickles reports as follows:—

“ The range of Intelligence Quotients was from 55 to 144, and the average (mean) Intelligence Quotient for all clinic children was 97.

The testing of educational attainments, particularly of reading, by standardised tests has continued as a routine part of the psychological examination of all children referred for full child guidance attention. This is important in indicating the degree to which children may be suffering from special learning difficulties associated with or attributable to their type of maladjustment. Special help may be offered in the clinic as part of the treatment procedure, and the psychologist has continued in a few selected cases to offer such help. At Harrogate, the clinic special class with a full-time special teacher has been operating throughout the year with considerable success, and there are indications that the demand for help from this class is exceeding the facilities available, and that it will continue to do so.

Of the total number of children tested in the clinics, 35, or 25%, were found to be significantly retarded in reading, the criterion being a discrepancy of 15 points or more between Intelligence Quotient and Reading Quotient. Degrees of reading retardation are given in the following table.

Degree of Retardation	50% plus	40% plus	30% plus	20% plus	15% plus	Totals
Boys	—	2	8	13	4	27
Girls	—	—	2	2	4	8
	—	2	10	15	8	35

The total number of handicapped children seen during the year by Mr. Pickles for special psychological examination was 85. Most of these had severe physical or sensory disabilities, were generally backward and borderline problems from the point of view of their capacity to benefit from special education, or had specific educational difficulties not necessarily related to emotional disturbance. A miscellaneous category includes a few adolescents, referred through the Youth Employment Service, and special problems such as that presented by a boy who had gained a grammar school place before suffering a serious cerebral hæmorrhage which left him physically incapacitated and intellectually impaired.

The following table gives an analysis of these children, arranged according to overlapping categories of disability and Intelligence Quotient.

Disability	No. seen	Untest- able	Below 50	50- 59	60- 69	70- 79	80- 89	90- 99	100- 109	110- 119	120- 129	Over 130
Cerebral Palsy	8	2	1	2	2	—	1	—	—	—	—	—
Blind/Partial Sight	4	—	1	1	—	1	1	—	—	—	—	—
Deaf/hard of hearing	12	—	1	1	3	2	2	—	3	—	—	—
General backwardness	32	1	16	10	2	3	—	—	—	—	—	—
Educational difficulties	13	—	1	5	2	2	1	—	1	1	—	—
Speech defects	8	—	—	1	4	—	1	1	—	—	1	—
Miscellaneous	10	—	—	—	—	2	2	3	2	—	—	1

Opportunities to visit several of the training centres for mentally sub-normal children in the County have been much appreciated, and it has been a pleasure to participate by giving talks at two of the refresher courses for staff of training centres held during the year."

Mr. H. B. Valentine reports as follows:—

"Attendance was made at the Child Guidance Clinics at Swinton, Ecclesfield (this clinic was held at High Green until August, 1960), Dalton, Woodlands and, occasionally, at Barnsley. Duties in addition to psychometric assessment and case conferences at the clinics included school visits, home visits, visits to other institutions, (e.g. Children's Homes and Remedial Centres) some interviewing of parents and the treatment of several children at two of the clinics which usually took the form of remedial tuition.

A number of children were tested at home or in school though conditions for testing in these surroundings varied from good to very poor.

A number of children who did not attend the clinics for full diagnosis and treatment were tested. These were usually seen because some special difficulty in assessing their I.Q. had been experienced, for example, some physical handicap or because they presented some special educational difficulty only.

School visits, which took up most of the time not spent in the clinics, involved gathering information about the children referred to the clinics and the explanation to the teachers concerned of the way in which the clinic team were trying to deal with these children's problems. Head and assistant teachers proved always to be very co-operative in providing the information requested and in offering to carry out any suggestions from the clinics which might help in the treatment of the children concerned.

Statistics

Number of children referred for full clinic investigation tested	..	..	..	196
Number of children not referred for full clinic investigation tested	..	..	..	20
Parents interviewed at clinics	..	..	..	24
School visits	..	..	..	62
Home visits	..	..	..	24 "

The School Ophthalmic Service:

As before the provision of ophthalmologists remains the responsibility of the Regional Hospital Boards. The clinic premises, equipment and the assistance of the nurse are all provided by the County Council. The clinics are affiliated to the various Hospital Management Committees, who are financially responsible for the provision and repair of glasses.

Large numbers of children continue to attend the School Ophthalmic Clinics and the number of examinations made and the number of children for whom glasses were prescribed during 1960 is given in the following table together with similar details for previous years:—

<i>Year</i>	<i>No. of children examined (including re-examinations)</i>	<i>No. prescribed glasses</i>
1948	10,755	8,113
1949	12,345	7,830
1950	12,341	7,289
1951	12,514	6,970
1952	14,974	8,941
1953	17,659	9,462
1954	17,691	9,240
1955	17,265	9,926
1956	17,644	9,999
1957	17,662	9,782
1958	18,829	9,472
1959	18,784	9,411
1960	20,651	10,029

Medical Treatment at Clinics:

As part of the Authority's arrangements under Section 48 of the Education Act, 1944, for the medical treatment of school children, the following clinics were in operation at the 31st December, 1960:—

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment and other non-specialised	203	—
Dental	44	—
Ophthalmic	—	58
Speech Therapy	50	—
Orthopædic Treatment Centres	17	—
Ultra Violet Light	43	—
Pædiatric	5	12
Chiropody	3	—
Consultant E.N.T.	—	15
Consultant Orthopædic	—	17
Consultant Dermatology	—	1
Consultant Cardiac	—	1

Consultant E.N.T. Service:

No. of sessions held	184		
	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
No. of individual children seen by consultant, including those continuing attendance from previous year	75	1,063	1,138
No. of above referred for operative treatment ...	56	534	590

	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
No. of Children:—			
(a) who obtained operative treatment ...	57	510	567
(b) treated at school clinics	1	57	58
No. of attendances at consultant clinics ...	92	1,548	1,640

Consultant Orthopædic Service:

Consultant Clinic

No. of sessions held	189
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	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
No. of individual patients seen by consultant, including those continuing attendance from previous year	347	936	1,283
No. of above—			
(a) referred for operative treatment as short- stay cases only	10	53	63
(b) recommended long-stay hospital school ...	—	3	3
(c) recommended treatment by orthopædic nurse or physiotherapist—			
(i) at treatment centres	19	89	108
(ii) domiciliary	6	8	14
No. of children who obtained operative treatment	4	38	42
Total number of attendances at consultant clinic	516	1,205	1,721

Treatment Centres

No. of sessions held	1,440
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	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
Total number of patients treated (including cases continuing treatment from previous year) ...	88	713	801
Total number of attendances	1,102	7,796	8,898

Domiciliary Treatment

	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
Total number treated	23	14	37
Total number of visits to patients' homes ...	64	76	140

Appliances

	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
No. of appliances—			
(a) recommended	33	85	118
(b) obtained	29	85	114

Consultant Pædiatric Service:

Consultant Clinics

No. of sessions held	...	..	...	...	202		
					<i>Pre-school</i>	<i>School</i>	
					<i>Children</i>	<i>Children</i>	<i>Total</i>
No. of individual patients seen—							
(a) New cases	...	...	...	...	124	205	329
(b) Cases attending from previous year	...				101	451	552
Total number of attendances at clinics	...	...			395	985	1,380

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

<i>Defect or Disease</i>						<i>Pre-school</i>	<i>School</i>	
						<i>Children</i>	<i>Children</i>	<i>Total</i>
Central Nervous System	...	...	...	...		5	16	21
Heart and Circulatory System	...	...	...	...		18	111	129
Respiratory System, including E.N.T. Defects	...					16	67	83
Speech	...	...	...	...	...	10	10	20
Orthopædic	...	...	...	...	...	11	13	24
Skin	...	...	...	...	...	6	7	13
Psychological	...	...	...	...	...	4	18	22
Mental Defect, including Educational Sub-								
normality	...	...	...	...	...	25	25	50
Congenital Deformities	...	...	...	...	...	15	4	19
Gastro-intestinal System	...	...	...	...	...	10	22	32
Epilepsy	...	...	...	...	...	12	44	56
Genito-urinary System	...	...	...	...	...	—	14	14
Glands	...	...	...	...	...	1	4	5
Nutritional	...	...	...	...	...	5	35	40
Developmental	...	...	...	...	...	43	38	81
Muscular Disease	...	...	...	...	...	1	5	6
Rheumatism	...	...	...	...	...	1	10	11
Habit Spasms	...	...	...	...	...	2	7	9
Incontinence	...	...	...	...	...	6	90	96
Migraine	...	...	...	...	...	1	40	41
Unclassified	...	...	...	...	...	37	65	102
						229	645	874

Ultra Violet Light Treatment:

At the end of the year there were 46 ultra violet light clinics in operation and the following are particulars of the children treated:—

Number of sessions held	...	...	...	2,186			
					<i>Pre-school</i>	<i>School</i>	
					<i>Children</i>	<i>Children</i>	<i>Total</i>
Number of children treated during year	...	...	...		377	813	1,190
Total number of attendances	...	...	...		4,752	10,871	15,622

Vaccination and Immunisation:

Particulars relating to the numbers of school children immunised against diphtheria during the year and the immunisation state of the population of children of school age will be found in the Section of the Report dealing with Epidemiology.

The scheme for the vaccination of school children against poliomyelitis continued throughout the year. Particulars of the scheme will also be found in the Epidemiological Section of the Report.

Vaccination and immunisation programmes required a further encroachment on school time and the ready and willing co-operation of the head teachers and their staff is much appreciated.

Cleanliness:

The following figures show the number of children found to be suffering from head infestation compared with previous years:—

Year	Total number of examinations made by school nurses	Number of individual children found to be infested	Percentage of school population
1947	368,370	24,862	11·3
1948	560,631	27,361	12·4
1949	574,968	23,457	10·5
1950	523,473	20,214	8·8
1951	559,388	18,599	7·9
1952	610,201	19,772	8·1
1953	575,645	17,815	7·1
1954	549,961	13,619	5·3
1955	547,369	11,657	4·5
1956	512,868	10,379	3·9
1957	481,239	10,459	3·9
1958	523,353	9,753	3·7
1959	482,874	9,834	3·6
1960	467,937	10,341	3·9

The percentage of school children found to be infested has remained fairly constant over the past five years, after the rapid improvement in the immediate post-war period.

Nutrition:

In 1956, the Minister of Education introduced a change in the classification of the general condition of school children. The table below is, therefore, in two parts.

It is, however, pleasing to note that continuous improvement has been maintained and the percentage of 0·88 unsatisfactory is less than half of the percentage recorded under this heading only five years ago.

Year	Total number of pupils inspected	Classification					
		A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1947	50,277	19,497	38.8	28,343	56.4	2,437	4.8
1948	71,858	26,077	36.3	41,876	58.3	3,905	5.4
1949	64,998	23,467	36.1	39,335	60.5	2,196	3.4
1950	61,977	26,820	43.3	33,528	54.1	1,629	2.6
1951	64,676	29,452	45.5	33,598	51.9	1,626	2.5
1952	62,156	30,506	49.1	30,635	49.3	1,015	1.6
1953	77,803	35,861	46.1	40,772	52.4	1,170	1.5
1954	79,553	40,315	50.7	38,344	48.2	894	1.1
1955	87,520	47,959	54.8	38,872	44.4	689	0.8
		Satisfactory			Unsatisfactory		
		No.	% of Col. 2	No.	% of Col. 2		
1956	89,564	87,318	97.50	2,246	2.50		
1957	83,250	81,524	97.90	1,726	2.10		
1958	84,346	83,025	98.43	1,321	1.57		
1959	88,398	87,484	98.97	914	1.03		
1960	83,630	82,892	99.12	738	0.88		

SCHOOL MEALS:

The number of meals provided to school children daily according to a check made in October, 1960, was 136,422 compared with 129,336 in October, 1959. This represents 55.3 per cent. of children on the registers.

Medical Examination of Entrants to Training Colleges:

In connection with their applications for entry to Training Colleges, 1,206 students were medically examined during the year by the School Medical Officers, compared with 1,116 for the year 1959 and 675 for the year 1958.

Children and Young Persons Act, 1933, Employment of Children:

Under the Authority's bye-laws relating to the employment of children, 1,321 children were examined during the year by the School Medical Officers to determine their fitness for employment. The figure includes children taking part in entertainments. Two cases only were found unfit.

Youth Employment Service:

The School Health Service has endeavoured to complete the medical examinations of school leavers in time to give the Youth Employment Service some indication of the type of work any child should *not* undertake. As a result of this procedure one general practitioner complained that medical information had been passed to the Youth Employment Officer by a School Medical Officer. In future, a letter will be sent to the parents of each school leaver to indicate that the Youth Employment Officer has received some guidance from the School Medical Officer regarding the placing of the child in employment. This letter has been compiled in consultation with the Youth Employment Officer and is known as Form Y.C.1 (Boy) or Y.C.1 (Girl).

When a school leaver is examined and found to be quite fit and healthy a Form called Y.C.6 is completed by the School Medical Officer and sent to the Youth Employment Officer. In the case of a severely handicapped child, a special Form designated Y.10 is completed, only if the parents' written consent has previously been obtained. This Form Y.10 is then placed inside a pouch of the Form Y.C.6 and sent to the Youth Employment Officer.

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF ENTRANTS:

Routine tuberculin testing of school entrants was undertaken in five Divisions. A total of 2,197 children were tested of whom 28 gave a positive result. These children were followed up through the Chest Physicians and X-rayed where considered necessary. Investigations were also made into the home contacts. Five new cases of tuberculosis were discovered as a result of these tests, two in children actually tested and three through following up contacts of positive re-actors.

Particulars of the Authority's scheme for the B.C.G. vaccination of school children and of the number of children dealt with during 1960 will be found in that part of the County Medical Officer's Report dealing with Epidemiology.

The Work of a Children's Specialist in the School Health Service:

The following notes relating to school children are taken from a report on the year's work submitted by Dr. Harvey, Pædiatrician:—

The most vexatious of stimuli to clinical experience is to find a child losing excessive time from school, usually with asthma or other manifestations of respiratory allergy. The reasons are often complex. Parents are afraid by reason of an asthmatic family history, or sometimes tuberculophobia, and they think that a child with a wheezing or a bubbly clogged airway must be kept at home or in bed until all manifestations have cleared up. Family doctors in some cases are excessively timid and work on the principle that a child must not return to school so long as any pips and squeaks are audible with the stethoscope. In cases of allergy this over-scrupulousness is entirely unprofitable, because such chests cannot be expected to lose all exudative signs. It is also overlooked that allergens are probably denser in the home than in the atmosphere of school, so that the child is likely to recover more quickly if reverted early to school. Parents commonly also give the excuse that they fear teachers will make trouble and send the child home with a reprimand if his ticklish cough is not entirely cleared up. I am not sure how far teachers themselves appreciate the importance of keeping a child regular at school so that he does not slip dolefully behind with his lessons. They probably assume that it is the doctor's responsibility to assess health, and they themselves must make the best job they can of inadequate attendance. With these allergic children, however, the doctors should go out of their way to get teachers to appreciate that it is better to keep a child in the class with some wheezing and coughing, than to wreck his education irretrievably by excessive absence in the foundation years, especially in the Infant School.

Migraine

The respectability of this affliction may perhaps go back beyond antiquity, and even before the dawn of history, to judge by the frequency with which Stone Age Frenchmen trephined each other. This year, several migrainous children have reported recurring nose bleeds during their attacks of engorgement of the circulation to the head.

Obesity surely is more like a theological than a medical problem. If young Britons and their parents were as afraid of immortality as American tycoons who live under the shadow of their coronary arteries, we should get better co-operation in dieting for overweight. They don't take us seriously in the suggestion that they need to go steadfastly hungry three times a day for six months. The problem is, admittedly, complicated by the apparent unfairness of Providence's discrimination against the obese, in that their slim friends can enjoy with impunity much more food than they use themselves.

The economic and social habits of the family have an evident bearing on the physiology and education of their children. This year, for instance, several children have been referred with imperfect bowel control and soiling of the underwear. The trouble mostly

happens during or later than afternoon school. It seldom seems that teachers have found any problem about it. These children are nearly all late getters-up in the morning, and my suggestion that they should rise before 7-00 a.m. to secure a morning bowel rhythm is ill-received by their parents, who apparently do not rise themselves till after 7-30. If the bowel can be normally cleared before morning school, the rectum will often stay empty through the important hours of the day, so that the problem of soiling would not arise. (The recent paper by Coekin, M. & Gairdner, D., 1960, Brit. Med. J., ii., 1175 on "Fæcal Incontinence in Children," looks like being as valuable a classic in its way as Gairdner's "Fate of the Foreskin" in 1949, which decided the abolition of circumcision for boy babies).

A 14 year old girl was recently referred with truanting which almost amounted to school phobia. She had been transferred by her father away from the Secondary Modern School where all her friends were to a school some miles away, and for many weeks she had refused to get up in the morning to attend, complaining of nondescript faint and dizzy sensations. The trouble was that both her parents left home at 7-10 every morning for work at a factory, and this girl and her small sister were left to fend for themselves unsupervised, and hence she found it easy to form a bad habit of avoiding school.

Numerous children are referred by their doctors with early morning sinking feelings and hunger colic which could sometimes be due to low blood sugar levels, and which almost always respond to giving a snack of food and drink on waking.

I was told during the year of a 14 year old boy who, without reference either to School Medical Officer or Child Guidance Psychiatrist, had been reverted from the Third Form of a Grammar School to become a Fourth Year Secondary Modern misfit. Neither the parents nor their advisers apparently had thought that the complaint of nightmares and sleep walking might benefit by medical or psychiatric help. The boy himself had adopted the uncultural short view that he wanted his evenings free from homework to go out with his pals.

One instructive personality problem was referred by the headmaster and school doctor, a 13½ year Secondary Modern boy who displayed a Jekyll and Hyde dual personality at school, sometimes biddable, sometimes irresponsible and irrational, clouting a prefect after apologising to the headmaster. He was found to have major nocturnal epilepsy which became well controlled by phenobarbitone, but in the daytime he was having frequent minor attacks which he well described lasting about six seconds, beginning with the *deja-vu* sensation of having lived through the situation before, and then his stomach turned over and a bitter taste came up into his mouth. Undoubtedly, his unpredictable behaviour at school could be attributed to active epileptic disturbances.

Chorea is one of the most tantalising disturbances associated with juvenile rheumatism because of its long duration and tendency to relapse. There is a temptation to consent to treating it at home when the circumstances are congenial, but almost always the attack is so prolonged that after many wasted weeks the child is admitted to hospital. This situation arose again this year with a Grammar School girl, an only child, from an admirable home, but after nearly 12 weeks of Summer holiday and term time had been wasted, she was eventually admitted to Professor Illingworth's ward and recovery followed in a fortnight.

Enuresis:

Redeployment in a big way is indicated by the manifest excellence of the electric buzzer treatment. My approach now is to start a new case with a check-list of the simple pitfalls in management such as:

- (a) diuretic evening drinks (tea, cocoa, coffee),
- (b) physical exhaustion of going too late to bed,
- (c) parents neglecting to lift the child at their bedtime,
- (d) or allowing him to sleep too late in the morning,
- (e) a blocked nasal airway.

If management fails and the bed is wet more than a quarter of the nights with a lifelong bed-wetter of school age, I would wish to use the buzzer next. Only if a month's course is unsuccessful would I reconsider for hospital in-patient study. Drug treatment has in the past been so unhelpful that I would ignore it. The administration of the buzzer outfits will afford the School Medical Officers and Health Visitors a considerable new field of clinical activity, and I would look forward to offering the buzzer to most bed-wetting children at five years of age.

During the year far too many girls, mostly Secondary Modern, but some even under 10 years old, are attending clinics with very tight pointed-toe fancy shoes. It is, I suppose, difficult for teachers to do anything about it, unless authoritative intensive health education could be brought to bear through the schools. It looks as if we are making a lot of work for orthopædic surgeons treating the next generation of adults.

Tailpiece:

“Discipline is the right of the child; he has as much right to be disciplined as he has to go to bed.”

Heard at Grantley Hall, Mr. J. B. Mays, 10th October, 1960.

Health Education in Schools:

Instruction in the principles of healthy living has long been regarded as an integral part of education in school. The responsibility for this work rests primarily with the teachers, who cover the subject either “incidentally”, i.e. in the course of teaching other subjects, or directly, by straightforward instruction in human biology and hygiene. The indirect method can be approached through a wide variety of subjects: housecraft, science, biology, physical education, geography, history, current affairs, and even mathematics all provide excellent opportunities for presenting the many and varied facets of health education. The knowledge so gained is then integrated and consolidated by direct teaching, which alone can ensure the appropriate balance of emphasis. It is in this latter sphere that so much valuable assistance can be given by medical officers and health visitors, more especially in those aspects of health education where more detailed or more up-to-date knowledge is essential. Examples include cigarette-smoking and its dangers, mothercraft, menstrual hygiene, prevention of infectious disease, the prevention of accidents, etc. The volume of such work has expanded very considerably in the last year or two, our recently appointed divisional nursing officers figuring prominently in a host of new programmes involving talks, discussions and films, more especially for the older girls and boys.

This progress should not however give rise to complacency. There are still many schools where, for a variety of reasons, health education is minimal. Direct teaching may often be non-existent and “incidental” teaching patchy and unco-ordinated. Some doctors and nurses, in the course of their talks and discussions with school children, have discovered many who, whilst remarkably well-informed on the constellations of outer space, reveal abysmal ignorance of the equally wonderful mechanisms within their own bodies and minds.

It was with a view to improving this situation that a number of extremely useful meetings were held in 1960 between teacher representatives on the Consultative Committee and officers of the County Medical Officer's Department. An account of these deliberations was prepared for publication in the West Riding County Council Education Committee Schools Bulletin and is reproduced herewith.

There was general agreement that many factors are at work which make the need for purposeful health education greater than ever before. It is true that a very great deal is already being done in schools. Very properly much of this is achieved incidentally and in a wide variety of subjects, e.g. Housecraft, General Science, etc. The more widely responsibility is spread, however, the greater the possibility that certain matters will be overlooked or understressed unless there is some arrangement within a school for co-ordination of effort so as to ensure that the whole of the essential field is covered. For this reason the teacher representatives were of the opinion that it would be helpful

if the County Medical Officer would prepare a list of topics which might well be considered for inclusion in any schemes of Health Education which might be drawn up by individual Secondary Schools. Accordingly the County Medical Officer has put forward the following suggestions:—

1. Elementary principles of personal health and hygiene, including diet, clothing, exercise, posture, recreation, rest, sleep, habits and addiction (e.g. smoking, alcohol, excessive sweet eating, unnecessary self-medication), cleanliness (especially of hands, feet, teeth, hair), dental health. (N.B. Mental health aspects should be included where appropriate).
2. Common infections and infestations; mode of spread; control and prevention; immunisation; care of food and milk in the home (dangers of contaminated food).
3. Sufficient basic anatomy and physiology to facilitate understanding of topics here referred to. There should be no deliberate exclusion of the physiology of reproduction which, for girls, can be used to introduce menstrual hygiene, care during pregnancy, care and management of infants.
4. The place of the child (and adolescent) in the family and the community. Privileges and responsibilities of children and parents; mental health aspects—emotional needs of children. Social problems in the community, e.g. the aged, the handicapped, the neglected. (Possible reference to the problems of the unmarried mother.)
5. Information concerning health and welfare services (national and local government); the work of sanitary authorities (district and borough councils) in housing, food hygiene, atmospheric pollution control, etc.
6. Prevention of Accidents—in the home and on the roads. Simple first aid.

It will be obvious that on the majority of school staffs there will be teachers competent and anxious to cover all of the subjects set out above. Even those with a special interest in these matters however may find it useful to consult Divisional Medical Officers and their staff about the most recent developments, such as, for example, in methods of immunisation. Divisional Medical Officers will be happy to advise on any public health topic and in many cases will be able to supply data and teaching aids which have been prepared for their own lectures. They would also be prepared to meet teachers individually or in groups to discuss their difficulties and, subject to the demands of their other duties, to speak to Parent/Teacher Associations where it was considered that this would be helpful. Indeed Divisional Medical Officers or members of their staff could be called upon to lecture in schools on any aspect of Health Education about which schools felt that their assistance would be valuable.

Learner Swimming Pools in Schools:

Various Parent/Teacher Associations have recently shown a very commendable interest in the provision of learner swimming pools in schools. The value of these pools to children is immediately recognised; swimming is, of course, a very healthy exercise and a small pool of shallow depth not only provides the means of learning to swim but also enables young children to realise the danger of entering deeper water before they can swim.

From the medical angle, however, it is essential to safeguard the health of the children using these pools and to ensure that everything possible is done to eliminate any danger of infection through pollution or water-borne disease. To this end discussions have taken place with the Chief Education Officer, the Divisional Medical Officers of Health and with the County Architect, as a result of which a memorandum governing the medical administration of these pools has been drawn up and agreed. This agreement, *inter alia*, limits the size of the pool, ensures that the water is from public supply and that samples are submitted frequently for bacteriological examination. It also specifies that the pool should be emptied and thoroughly cleansed weekly, along with an efficient system of water sterilisation. Finally any proposed scheme for a learner swimming pool must be submitted to the County Medical Officer, the County Architect and to the Medical Officer for the district concerned for prior approval and it is emphasised that the Medical Officer of Health may take action, including the closure of the pool, limitation of use, etc., to prevent or limit the spread of infection, should he deem such action necessary.

THE SCHOOL DENTAL SERVICE

The following is the Report of the Principal School Dental Officer, Dr. Davies.

For the first three months of the year the School Dental Service was administered by my predecessor and it was on the 20th May that I took up duty as Chief Dental Officer. Things have never been easy for the school dental service but there has been established in the West Riding a well-organised dental service limited in its development only by national factors beyond local control, the most outstanding of which at the present juncture is the difficulty of recruitment of dental surgeons.

Staff:

The establishment remained at 62 school dental officers, five senior dental officers, one orthodontic consultant and a chief dental officer. At the end of the year there were employed a chief dental officer, an orthodontic consultant, four senior dental officers and 34 school dental officers. In addition 25 part-time dental officers were employed giving the equivalent in sessions of a further six full-time officers. This represents a loss of five full-time officers and a gain of five part-time officers compared with December, 1959. One thousand, one hundred and thirty-five evening sessions were worked by the full-time staff representing the equivalent of additional three full-time officers. The trend in recent years has been for the number of full-time officers to decrease and that of part-time officers to increase, and this tendency is still evident. Since the inception of the National Health Service, in spite of nationally negotiated salary scales and conditions of service for school dental officers, full-time recruitment has been practically at a standstill. This is due not only to the fact that remuneration is higher in the General Dental Service and the Hospital Service as was made clear by the Royal Commission on Doctors' and Dentists' Remuneration published in February, but also to the fact that the public demand for dentistry exceeds the available supply and the advantages of employment by local authorities which were considerable before 1948, such as security and superannuation, are now available elsewhere.

In these circumstances the service is grateful for the assistance given by part-time dental officers but the situation cannot be regarded with equanimity for an adequate service is dependent on the devotion of dental surgeons whose only professional interest is in the school dental service. The planning of the

service even in the area covered by a single surgery can best be undertaken by full-time staff and while part-time help is very much appreciated it would be a tragedy if full-time officers were to be replaced rather than assisted by part-time employees. Part-time service tends to be sporadic and temporary and recruits are drawn largely from the ranks of the newly qualified whose main interest is in the building up of a private practice elsewhere. It is hoped that now compulsory National Service for dental surgeons has ended there will be an improvement in recruitment to the school dental service.

Clinics and Equipment:

New clinics were opened during the year at Horsforth, Parson Cross and Wombwell, in each case in association with the medical services. Modernisation and improvements were effected at the Pudsey and the Ossett clinics. A total of 44 permanent fixed clinics now exist in the Riding and in spite of staffing difficulties all were in operation during the year albeit in some cases to a very limited degree. It was anticipated that the two oldest mobile dental surgeries would be replaced but owing to a resignation only one replacement was effected.

A major advance in dental equipment in recent years has been the introduction of the ultra high speed instrument for the more rapid removal of tooth substance with less discomfort for the patient and less fatigue for the dentist. These instruments seem to fulfil more of the desirable requirements and have fewer undesirable features than other instruments for restorative operative procedures and it is a safe prediction that high speed rotational instruments will be essential in future dentistry. Twelve surgeries were fitted with this equipment during the year bringing the total in the county to 25. This equipment is a far cry from that used in former years when dental officers were peripatetic and set up their portable surgeries in temporary premises. I am pleased to report that this year has seen the end of full-time peripatetic dentistry in the county. It is impossible to practise modern dentistry as taught in the dental schools to-day without permanent well equipped surgeries, and if these had not been provided recruitment of additional staff would have been out of the question altogether.

Inspection:

In spite of the drop in the number of full-time officers a similar number of children was inspected as last year, 117,300 compared with 117,646 were inspected in school and 9,494 special inspections were made compared with 9,922 in 1959. Less children however were found to be in the need of treatment, 88,958 compared to 92,097 which seems to indicate that the increase in dental decay noted in the post-war period may well have reached its peak, an impression that is borne out by the reports of some individual officers who noted during school inspections an increase in the number of children with caries free mouths.

The difference between the number of children found to require treatment and the number of those offered treatment represents the extent to which dental officers in present circumstances must exercise discrimination. In a fully staffed service all children found to require treatment would be given the opportunity to receive it but discretion must be exercised in the selection of patients and the extent and type of treatment offered, when professional staff is limited in numbers.

It is important to realise in this connection not only that treatment was not offered to 16,978 children who would have benefited by it but that 150,000

children were not even inspected during the year. It is impossible to be complacent in view of these facts. More than twice our present number of dental officers would be required to inspect all the West Riding school children annually and to carry out all the treatment found necessary, and this should be regarded as our minimum target. Very few dental surgeons are content to see their child patients only once a year.

Treatment Trends:

The pattern of treatment has been the same as in former years but the statistical returns of treatment provided reflect the decrease in staff. Two thousand, four hundred and thirty half-days less were devoted to treatment than in 1959 and 49,310 children were treated compared with 53,138 the previous year. Although the figures relating to items of work are necessarily lower than last year's it is of interest to note that compared with 1958 when a similar number of half-days were devoted to treatment (18,739 compared to 18,188 this year) the number of permanent teeth filled has increased and the number of permanent teeth extracted has decreased. This shows a healthy trend in the nature of the treatment required and of that provided. The latter is undoubtedly due to the provision of better accommodation and equipment. At half-days devoted to extractions under general anaesthesia the anaesthetics are administered by dental officers for each other. This arrangement works well and is advantageous from many points of view, not the least being that a second opinion is available for all cases of doubt especially where extractions are undertaken for reasons other than pain and sepsis. One thousand, two hundred and nine half-days were spent during the year on the administration of general anaesthetics and 7,753 teeth both temporary and permanent were extracted for orthodontic reasons.

The attention of the Education Committee has been drawn during the year to the dental dangers attendant on the increased use of school tuck shops. These dangers are due to the facts that the foodstuffs commonly sold are those most liable to cause tooth decay, that inadequate facilities are available for subsequent tooth cleaning and that between meal snacks lower the resistance of the mouth over the whole day.

The sale of confectionery in schools is not defended on the grounds that it is nutritionally desirable, indeed the Chief Medical Officer of the Ministry of Education has remarked that obesity in children is now attracting at least as much attention as undernutrition, and it is well-known that its chief purpose is the accumulation of profits in order to supplement school funds.

In extenuation it is said that children will obtain sweets elsewhere if they are not made available at school and that no benefit will be gained by prohibiting sales. It is possible however that in some cases at least the sweets bought in school are an addition to and not a substitute for sweets bought elsewhere.

There are two main reasons why the practice should be discouraged, one practical and one ethical. First, the health of the mouth benefits from periods of rest and not facilitating eating during school hours will directly benefit the dental health of children by ensuring the teeth a period of freedom from food debris. Second, it is important that educational establishments should not condone a practice which is defiant of known health principles and in consequence directly opposed to health education teaching. This is particularly important at a time when we are grievously short of dental staff,

but in any case places the Education Committee in the position of speaking with two opposing voices which is highly undesirable.

General Remarks:

In the face of all sorts of difficulties immense efforts have been made since the inauguration of the school dental service to provide more and more children with the opportunity of receiving treatment, but it has gradually come to be realised that while full treatment for every child is one aim of the service it should not be its only purpose and perhaps not even its main one. Unlike the school health service which has always been directed at the prevention of ill-health the dental service has been almost entirely a reparative service, virtually the whole of its work being the treatment of established dental disease. A growing realisation of the vast and costly organisation that is required to provide a complete reparative service for the now overwhelming amount of disease that exists in school children no longer allows us to ignore the need for prevention, and makes urgent demands for the implementation of known preventive measures.

It has long been known that certain minerals and vitamins, together with a properly balanced diet, are needed to ensure teeth of sound structure which will be resistant to decay. Much has been done to disseminate knowledge of these principles and to make provision for dietary supplements when needed, and cases of malnutrition in expectant mothers and growing children sufficiently severe to affect the teeth are now rare. There is however one outstanding exception about which much remains to be done. There is really no doubt now that minute amounts of the element fluorine when contained in drinking water reduce very considerably indeed the incidence of decay in children. There is really no doubt that this minute amount of fluorine is without adverse effect on the body as a whole, even when consumed over a life-time. The Ministry of Health has commenced trials in three parts of the United Kingdom and it is to be hoped that final results will shortly be forthcoming and will be followed by a general adoption of fluoridated water.

More important now than basic dietary matters is the problem of dietetic indiscretion such as excessive eating between meals, together with its corollary neglected oral hygiene. Spectacular results cannot be gained by controlling these factors but it is certain that limiting the consumption of sweets, biscuits and chocolates, and keeping the teeth clean for several reasonably long periods of the day do effectively reduce dental decay. These are matters which lie within the control of each individual. They need to be taught and publicised widely. The extent of decay at present is a measure of the failure of dental health education.

It is not possible yet to prevent dental disease entirely and the most effective means of control is still early dental treatment. Regular and frequent dental inspections are essential if decay and other abnormalities are to be tackled before serious developments have occurred. Until school inspections can be carried out at least twice each year the school dental service does not really have a chance to be effective. A strong and vigorous school dental service is the greatest need in our battle against dental disease.

THE SCHOOL ORTHODONTIC SERVICE

The following is a Report by the Consultant Orthodontist, Miss Sclare.

When Mr. B. R. Townend retired in April from his position as Chief Dental Officer he also retired from his position as Orthodontic Consultant. He left behind him an orthodontic service which he had developed from nothing to one of which the West Riding has every reason to be proud, and we are endeavouring to the best of our ability to maintain the very high standard set by him.

To help to fill the gap created by Mr. Townend's retirement two officers, Mr. G. Thompson and Mr. J. F. Gravely, are treating patients for two sessions per week on alternate weeks at the Central Dental Clinic.

Besides the treatment done in the clinics specially equipped for orthodontic work (there are eight of these in the Riding in addition to the Central Dental Clinic), a considerable amount of work of the simpler type is being done by many members of the staff. Written advice and guidance on the treatment of cases is given wherever necessary on the receipt of models at the Central Dental Clinic and if a dental officer so wishes he can attend at any of my clinics for a course of instruction. Encouragement is given to officers to do this work, for not only does it relieve the pressure on the orthodontic clinics but adds variety to the rather monotonous routine work of filling and extracting teeth which is the basis of children's dentistry. A modified orthodontic service is now available in most parts of the county, thus considerably reducing the need for long journeys to the special orthodontic clinics.

The demand for orthodontic treatment continues to grow year by year. In 1959 the number of cases under treatment was 4,216 and in 1960 it had risen to 4,656. Of this number 1,757 were treated with appliances in 1959 and 2,396 in 1960, an increase of 659. There has been a slight drop in the number of fixed appliances fitted, 298 in 1959 as opposed to 287 in 1960. This is due to the improved technique in the structure of removable appliances. Recent improvements in retention have made it possible to use removable appliances in a number of cases where fixed appliances were once necessary. This is a great saving in chairside time. There still remains, however, a number of cases which are best treated by fixed appliances and these appliances, which require a considerable degree of skill, can only be made at the clinics specially equipped for this purpose.

During the year we have introduced a number of new appliances. In this connection I would like to record my deep appreciation of the work done by the dental technicians who have never failed to co-operate in the designing and making of new appliances. Their interest and enthusiasm have been of great help and encouragement to me.

Dental Inspection and Treatment Carried Out during the Year:

Number of Pupils inspected by Authority's Dental Officers—

At Periodic Inspections	...	...	...	...	...	...	117,300
As Specials	...	...	...	...	...	...	9,494
						Total	126,794

Number found to require treatment	...	...	...	...	...	...	...	88,958
Number offered treatment	...	...	...	...	...	...	...	71,980
Number actually treated	...	...	...	...	...	...	...	49,310
Number of attendances made by pupils for treatment	...	...						128,211
Half-days devoted to—								
Periodic (School) Inspection	...	...	...	...	...	...	...	1,101
Treatment	...	...	...	...	...	...	...	18,109
							Total	19,210
<hr/>								
Fillings—								
Permanent	...	...	...	...	...	...	...	94,608
Temporary	...	...	...	...	...	...	...	4,332
							Total	98,940
<hr/>								
Number of teeth filled—								
Permanent	...	...	...	...	...	...	...	81,193
Temporary	...	...	...	...	...	...	...	4,092
							Total	85,285
<hr/>								
Extractions—								
Permanent	...	...	...	...	...	...	...	18,875
Temporary	...	...	...	...	...	...	...	50,340
							Total	69,215
<hr/>								
Administration of General Anæsthetics for Extraction	...	...						20,396
Orthodontics—								
Cases commenced during year	...	...	...	...	...	...	...	1,468
Cases carried forward from previous year	...	...	...	...	...	...	...	3,188
Cases completed during the year	...	...	...	...	...	...	...	907
Cases discontinued during the year	...	...	...	...	...	...	...	221
Pupils treated with appliances	...	...	...	...	...	...	...	2,396
Removable appliances fitted	...	...	...	...	...	...	...	1,946
Fixed appliances fitted	...	...	...	...	...	...	...	287
Total attendances	...	...	...	...	...	...	...	18,938
Number of pupils supplied with artificial dentures	...	...						766
Other operations—								
Permanent	...	...	...	...	...	...	...	24,185
Temporary	...	...	...	...	...	...	...	2,019
							Total	26,204
<hr/>								

KEIGHLEY EXCEPTED DISTRICT

The following report on the year's work is submitted by Dr. McDonagh, the Borough School Medical Officer to the Keighley Excepted District.

Introduction:

This report is compiled in accordance with arrangements made by the County Council of the West Riding of Yorkshire as to the School Health Service in the Borough of Keighley and details the work carried out during the year under review.

The most important change during the year was the introduction of a selective scheme of medical examination of children, full details of which will be found in the report. As the scheme has been in operation for only a year it is, of course, too early to draw any firm conclusions. However, with the increasing standards of physical health of children it would appear inevitable that the time must eventually arrive when the routine medical examination of normal children is no longer justifiable and other more dynamic means of discovering physical and mental defects will require to be developed. Consequently this, and similar experiments along these lines which are being carried out throughout the country, must tend in time to give us a lead towards the pattern of school medical inspection of future years.

While considering revised methods of medical inspection a short comment on the health visiting/school nursing service might be appropriate. In Keighley we are fortunate to have a completely combined service of this kind. Nevertheless these highly qualified staff spend a large proportion of their time carrying out various duties such as weighing and measuring of school children, assisting at routine medical inspections and re-inspections, cleansing of verminous heads etc. which could be done with equal efficiency by not so highly qualified nursing staff, for example state enrolled assistant nurses. The fully qualified health visitors could then be concentrated where they would be most useful, which is in advising parents on the health and welfare of their children and co-operating with the teaching staff in instruction on various aspects of child care, personal hygiene and elementary human biology. Although a small amount of work has been done in the schools along these lines during the year there remains great scope for the further extension of this approach and we must hope that in the very near future the health visitor will take her proper place in the teaching of hygiene and health education in the schools.

Medical Inspections of School Children:

SELECTIVE SCHEME:

From the beginning of the year the two intermediate routine medical inspections of all scholars were discontinued and instead a scheme of selective medical examinations was introduced. It was hoped that the new scheme would operate as follows:—

- (1) Full routine medical inspection of all children at the age of five years carried out on each term intake.

- (2) Full routine medical inspection of all school leavers. In the case of secondary modern schools, this medical inspection would take place as early as practicable in the child's final year so that there would be adequate time to deal with defects not previously discovered.
- (3) Children requiring medical attention would be referred to their private doctor or dealt with at the school clinic as the case required. Children requiring observation only would be followed up at each subsequent visit to the school.
- (4) Frequent visits to the schools would be carried out by the school medical officers and health visitor/school nurses. On their visits the school medical officers would confer with the head teachers and assistant teachers about any child who appeared to require medical attention or who was not benefiting fully from its education and would also observe the children at work and play and in the gymnasium, paying close attention to the social maturity and emotional development of the child.
- (5) At about the time of transfer from Infant to Junior School, i.e. eight years, a questionnaire, together with an explanatory letter, would be sent to all parents.
- (6) Tests of visual acuity would be carried out on all children aged 7, 11 and 13.
- (7) An audiometric survey would be carried out on all seven year old children. Those with hearing loss would be examined by the school medical officer and referred to their private doctor or the E.N.T. specialist if a true defect was found.
- (8) Health visitor/school nurses would carry out the usual cleanliness inspections and would be on the look-out for any child whose social or medical condition might require the attention of the school medical officer.
- (9) Close liaison would be maintained between the medical, nursing and teaching staff.
- (10) The physiotherapist would visit schools whenever possible to discuss with the physical education teacher the treatment of minor postural and foot defects. It is considered that a tremendous amount of good could be achieved by properly informed and enthusiastic physical teachers.

In general the change over to the new scheme was carried out smoothly. Unfortunately the questionnaire which was sent to the parents of eight year old children was in many instances carelessly and inaccurately completed, the information given not tallying with either known information or that obtained on closer questioning. In view of this much valuable time was wasted in examining them and of necessity more children were examined than would perhaps have been the case if the answers had been given with greater accuracy. Complaints from parents were largely confined to the condition of upper respiratory tract and to bed wetting. On examination few of the former appeared to be of significance and in the case of bed wetting few parents seemed to be able to find the time to attend the clinic at the appointed time for consultation with the medical officer. On this aspect it is worth observing that the response of parents to attend the special examination of their children was very poor. In addition the school medical officer re-examined all children who were already found to require observation at earlier routine inspections.

While it is intended to continue with the questionnaire other methods of selecting cases for examination are being considered, for example close observation of a group of children, say at the time of the tests for visual acuity.

The tests of visual acuity in the age groups 7, 11 and 13 were decided on after consultation with the consultant ophthalmologist who thought that these ages were the most suitable. Assuming that cases of gross visual defects and strabismus are detected at the routine entrance examination or earlier, seven years of age was considered to be the earliest when large groups of children could be successfully tested. It was anticipated that at this age cases of non-squinting amblyopic eyes would be successfully selected and treated.

The test at 11 years of age would select less severe defects and any which may have remained undiscovered earlier. Thirteen years was considered to be a suitable age to test colour vision and also to discover cases of adolescent myopia. This year it was necessary to test the vision of eight year olds, otherwise this would not have been done until the age of 11 years.

An audiometric survey was carried out on seven year old children. Of the 603 children tested 34 were considered to require re-examination and of these 11 were found to have defective hearing. Nine of the 34 children failed to keep appointments for the individual tests. Of the children with defective hearing three were already under treatment by the otologist, two children were treated at the school clinic, four referred to their private practitioner for treatment and two referred to the otologist. In one case the otologist recommended an electric hearing aid and the other case was admitted for investigation and eventually had his adenoids removed. However, it is of interest that 40 were referred as a result of special examinations by the school medical officer on visiting the schools and of these 11 were found to have defective hearing, six were treated at the school clinic for excessive wax and five referred to the otologist. All these were found by him to have defects requiring expert attention. In one case a boy was referred as an E.S.N. child but found on examination to be suffering from marked deafness as a result of respiratory tract infection. After treatment in hospital he learnt to read within a few weeks.

During the visits to the schools and discussions with the teachers by medical and nursing staff children were brought to notice who required further examination and treatment and although this arrangement put a greater responsibility on the teaching and nursing staff, from the evidence available it is not considered that any child requiring expert attention was overlooked. While all children will only be submitted to a routine medical examination on two separate occasions during their school life it must be remembered that in addition seven year olds received an audiometric test and children of 7, 11 and 13 had their vision tested, and, of course, were closely observed and questioned as to their general health during these tests. From previous experience it is clear that apart from enlarged tonsils and adenoids the majority of defects found in children during intermediate examination are defects of eye and ear. Clearly the medical examination of entrants and leavers is of great importance; the first examination ensures that all detectable defects are recorded and remedied in consultation with the child's private doctor, many defects it may be said unobserved by parents or not serious enough to be brought to the notice of the private doctor. The final routine inspection will in time serve as an evaluation of the selective examination scheme, and, of course, also enables the school medical officer to advise the parents and youth employment officers about the work which might be unsuitable for that particular child. This, of

course, applies especially to the handicapped school leaver where, a special form, with the parents' agreement, is passed on to the youth employment officer to assist him in the proper placement of the child.

It must be emphasised that the selective examination scheme is more consuming in time and labour on the part of all staff, medical, nursing and clerical, but after such a short period of trial it is difficult as yet to give a firm estimate. The school medical officer is the leader of a team, involving the health visitor/school nurse, the head teacher and his colleagues, the success of which will undoubtedly depend upon an extremely close and friendly co-operation between all concerned.

The number of pupils on the registers at the end of the year is shown below together with the figures for the previous year:—

	1960	1959
Nursery	40	40
Primary	4,889	4,795
Secondary Modern	2,257	2,296
Secondary Grammar	1,511	1,485
Secondary Technical	470	472

TABLE I
MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND
SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A. Periodic Medical Inspections

Age groups inspected (by year of birth) and number of pupils examined in each:

<i>Year of Birth</i>			
1956 and later	...	...	60
1955	...	...	449
1954	...	...	132
1953	...	...	23
1950	...	...	10
1949	...	...	16
1948	...	...	11
1947	...	...	14
1946	...	...	378
1945 and earlier	...	...	378
Total			1,471

B. Other Inspections

Number of Special Inspections	...	3,018
Number of Re-Inspections	...	1,532
Total		4,550

C. Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (Year of birth)	For defective vision excluding squint	For any of the other conditions recorded in Table III	Total Individual Pupils
1956 and later	—	4	4
1955	—	67	67
1954	—	23	23
1953	2	4	5
1950	—	1	1
1949	1	1	2
1948	1	1	2
1947	1	1	2
1946	20	12	31
1945 and earlier	15	35	45
Total	40	149	182

D. Classification of the Physical Condition of Pupils inspected in the Age Groups Recorded in Table I.A

Age Groups inspected (Year of birth)	Number of pupils inspected	Satisfactory		Unsatisfactory	
		No.	Percent. of Col. 2	No.	Percent. of Col. 2
1956 and later	66	66	100·0	—	—
1955	449	449	100·0	—	—
1954	132	132	100·0	—	—
1953	23	23	100·0	—	—
1950	10	10	100·0	—	—
1949	16	16	100·0	—	—
1948	11	11	100·0	—	—
1947	14	14	100·0	—	—
1946	378	378	100·0	—	—
1945 and earlier	378	378	100·0	—	—
Totals	1,471	1,471	100·0	—	—

TABLE II
INFESTATION WITH VERMIN

The scheme for ensuring cleanliness at schools within the Borough provides, as far as possible, for the inspection of children and their clothing once during each school term throughout the year.

Details of the work carried out are given in the following table:—

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	... ..	17,188
(ii)	Total number of individual pupils found to be infested	...	545
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	...	—
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	...	—

TABLE III
DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED
31ST DECEMBER, 1960

All defects noted at medical inspection as requiring treatment are included in the following tables, whether or not this treatment was begun before the date of the inspection.

A. Periodic Inspections

Defect Code No.	Defect or Disease	Periodic Inspections							
		Entrants		Leavers		Others		Total	
		(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
4	Skin	6	10	8	1	—	—	14	11
5	Eyes— <i>a.</i> Vision	—	3	35	90	5	1	40	94
	<i>b.</i> Squint	7	14	—	1	—	1	7	16
	<i>c.</i> Other	1	1	—	—	—	—	1	16
6	Ears— <i>a.</i> Hearing	1	3	3	9	2	1	6	13
	<i>b.</i> Otitis Media	1	1	—	1	—	1	1	3
	<i>c.</i> Other	—	2	1	—	—	—	1	2
7	Nose and Throat	36	67	1	8	1	2	38	77
8	Speech	9	1	3	—	1	1	13	2
9	Lymphatic Glands	—	7	1	—	—	—	1	7
10	Heart	1	12	3	4	—	—	4	16
11	Lungs	4	13	—	4	—	—	4	17
12	Developmental— <i>a.</i> Hernia	—	—	—	—	—	—	—	—
	<i>b.</i> Other	—	16	—	2	—	1	—	19
13	Orthopædic— <i>a.</i> Posture	7	8	11	7	1	—	19	15
	<i>b.</i> Feet	23	13	6	3	—	—	29	16
	<i>c.</i> Other	6	11	2	5	2	—	10	16
14	Nervous System— <i>a.</i> Epilepsy	—	—	—	2	—	—	—	2
	<i>b.</i> Other	—	1	—	—	—	—	—	1
15	Psychological— <i>a.</i> Development	1	1	—	—	—	—	1	1
	<i>b.</i> Stability	—	5	—	2	—	1	—	8
16	Abdomen	5	1	—	—	—	—	5	1
17	Other	4	4	13	11	—	1	17	16

B. Special Inspections

Defect Code No.	Defect or Disease	Special Inspections	
		Requiring Treatment	Requiring Observation
4	Skin	148	31
5	Eyes—a. Vision	228	572
	b. Squint	28	51
	c. Other	36	6
6	Ears—a. Hearing	28	51
	b. Otitis Media	38	23
	c. Other	10	9
7	Nose and Throat	76	135
8	Speech	126	35
9	Lymphatic Glands	7	12
10	Heart	2	58
11	Lungs	59	57
12	Developmental—a. Hernia	—	1
	b. Other	5	38
13	Orthopædic—a. Posture	23	12
	b. Feet	73	41
	c. Other	54	35
14	Nervous System—a. Epilepsy	7	5
	b. Other	2	8
15	Psychological—a. Development	191	63
	b. Stability	14	46
16	Abdomen	4	5
17	Other	183	79

TABLE IV
TREATMENT OF PUPILS

Notes

The figures given under this heading include:—

- (i) cases treated or under treatment by members of the Authority's own staff;
- (ii) cases treated or under treatment in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board; and
- (iii) cases known to the Authority to have been treated or under treatment elsewhere.

Group 1. Eye Diseases. Defective Vision and Squint

	Number of cases known to have been dealt with	
	1960	1959
External and other, excluding errors of refraction and squint ...	58	46
Errors of refraction (including squint)	213	188
Total	271	234
Number of pupils for whom spectacles were prescribed	149	150

During the year 185 cases of defective vision and 28 cases of squint were examined by the visiting Ophthalmic Surgeon, a further 58 cases suffering from other conditions of the eye such as Blepharitis and Conjunctivitis were treated at the Minor Ailments Clinic.

After testing there were 45 cases in which spectacles were not prescribed, 16 cases where existing spectacles were found to be satisfactory and 23 cases referred to the Bradford Eye and Ear Hospital.

The number of repairs to and replacements of spectacles amounted to 218.

Group 2. Diseases and Defects of Ear, Nose and Throat

							Number of cases known to have been dealt with	
							1960	1959
Received operative treatment:								
(a)	for diseases of the ear	...	...	...	...	...	—	—
(b)	for adenoids and chronic tonsillitis	...	...	...	...	...	180	218
(c)	for other nose and throat conditions	...	...	...	...	...	14	27
Received other forms of treatment		...	...	...	...	...	44	30
Total		...	...	...	...	...	238	275
Total number of pupils in schools who are known to have been provided with hearing aids								
(a)	in 1960	...	...	...	...	...	2	
(b)	in previous years	...	...	...	...	...	1	

Group 3. Orthopædic and Postural Defects

							Number of cases known to have been dealt with	
							1960	1959
(a)	Pupils treated at clinics or out-patient departments	...	...	...	...	...	220	242
(b)	Pupils treated at school for postural defects	...	...	...	...	...	—	—
Total		...	...	...	...	...	220	242

Consultant Clinic:

Number of sessions held	...	...	...	...	...	...	7	
Number of individual patients seen by consultant, including those continuing attendance from previous year							10	14
Number of above—								
(a)	referred for operative treatment as short-stay cases only	...	...	...	...	...	—	—
(b)	recommended long-stay hospital school	...	...	...	...	...	—	—

(c) recommended treatment by orthopædic nurse or physiotherapist—							
(i)	at treatment centres	...	...	...	...	...	2 4
(ii)	domiciliary	...	...	...	...	...	— —
Number of children who obtained operative treatment						—	—
Total number of attendances at consultant clinic						18	30

Treatment Centres

Number of sessions held	...	...	...	...	...	...	500	
								<i>Pre-school School</i> <i>Children Children</i>
Total number of patients treated (including cases continuing treatment from previous year)						...	6	220
Total number of attendances						...	91	2,827

Domiciliary Treatment

Total number treated	...	...	...	...	...	...	—	—
Total number of visits to patients' homes	...	...	...	...	...	...	—	—

Appliances

Number of appliances—(a) recommended								...	...	—	—
(b) obtained								...	...	—	—

Physiotherapy

The following shows details of the work undertaken by the Authority's Physiotherapist.

<i>School Children</i>							<i>No. of Cases</i>	<i>Attendances</i>
Asthma	...	...	...	...	...	...	9	82
Breathing	...	...	...	...	...	...	48	534
Remedial Exercises	...	...	...	...	...	...	1	10
Cerebral Palsy	...	...	...	...	...	...	1	35
Anterior Poliomyelitis	...	...	...	...	...	...	1	69
Flat feet	...	...	...	...	...	...	84	1,158
Hemiplegia	...	...	...	...	...	...	2	28
Lordosis back	...	...	...	...	...	...	1	9
Poor chest development	...	...	...	...	...	...	9	70
Posture	...	...	...	...	...	...	30	442
Postural drainage	...	...	...	...	...	...	3	83
Round shoulders	...	...	...	...	...	...	21	171
Scoliosis	...	...	...	...	...	...	6	54
Spastics	...	...	...	...	...	...	1	49
Stoop	...	...	...	...	...	...	3	33
Total						...	220	2,827
<i>Pre-school Children</i>								
Flat feet	...	...	...	...	...	...	5	79
Posture	...	...	...	...	...	...	—	—
Torticollis	...	...	...	...	...	...	1	12
Total						...	6	91

Group 4. Diseases of the Skin (excluding uncleanness for which see Table II)

									Number of cases known to have been treated	
									1960	1959
Ringworm—(a) Scalp	...	...	...	...	...	...	...	...	—	—
(b) Body	...	...	...	...	...	...	...	...	—	6
Scabies ...	...	...	...	...	...	...	...	...	62	46
Impetigo ...	...	...	...	...	...	...	...	...	61	50
Other skin diseases	...	...	...	...	...	...	...	...	22	61
Total ...									145	163

As in previous years a large part of the work carried out at the minor ailments clinic consisted of the treatment of cuts, abrasions, septic fingers and skin diseases.

Group 5. Child Guidance Treatment

During the year 26 maladjusted pupils attended the clinic, four were old cases and 22 new referrals. Of these seven were referred to the Consultant Child Psychiatrist at the Shipley Clinic, a further sixteen cases from previous years were kept under observation. These figures do not include children who are attending the Braithwaite E.S.N. School, many of whom are psychologically disturbed.

From the above it will be seen that many of the referrals for disturbance were not of a serious nature and treatment was carried out by the School Medical Officer at the Clinic.

The monthly case conferences continued during the year and served to enlarge the experience of doctors and school nurses in child psychiatric problems.

The following is an analysis of the recommendations made:—

At Residential School for Maladjusted Girls	...	...	...	1
Hostel for Maladjusted Boys recommended	...	...	...	1
Recommended for Day E.S.N. School	...	...	...	1
Recommended for Residential School for Maladjusted Boys	...	...	...	1
Recommended for Residential School for E.S.N. and Maladjusted Boys and admitted	...	...	...	1
Referred to E.N.T. Surgeon	...	...	...	1
Referred to or under care of Pædiatrician	...	...	...	2
Referred to or under care of Child Guidance Clinic	...	...	...	7
Treated at School Clinic	...	...	...	8
Observation in School	...	...	...	3

Group 6. Speech Therapy

					Number of cases known to have been treated	
					1960	1959
Pupils treated by speech therapist	...	...	...	...	90	79

The services of a speech therapist, half-time, are available to the Authority and a glance at the table showing the number of cases awaiting treatment at the end of the year will amply demonstrate the fact that we could utilise a whole-time speech therapist.

Details of the work carried out by the Authority's Speech Therapist are set out below:—

Total number of sessions held	...	...	...	...	...	...	209
(a) Number of new cases treated	...	...	...	...	...	...	50
(b) Number of cases already attending for treatment from previous year	...	...	...	...	...	...	40
(c) Total number of cases treated (a + b)	...	...	...	...	...	...	90
Number of cases awaiting treatment at end of year	...	...	...	...	...	...	74
Number of visits made to schools	...	...	...	...	...	...	3
Number of home visits	...	...	...	...	...	...	—

<i>Analysis of Cases Treated</i>							<i>Boys</i>	<i>Girls</i>
Stammering	...	...	...	...	...	...	20	3
Defects of articulation—								
(a) Dyslalia	...	...	...	...	...	...	37	14
(b) Sigmatism	...	...	...	...	...	...	6	2
(c) Rhinolalia, due to (i) Cleft palate	...	...	...	...	...	...	1	—
(ii) Nasal obstruction	...	...	...	...	...	...	—	—
(d) Dysarthria	...	...	...	...	...	...	1	1
Aphasia	...	...	...	...	...	...	—	—
Defective speech due to (i) Educational sub-normality	...	...	...	...	...	...	3	1
(ii) Deafness and Educational sub-normality	...	...	...	...	...	...	1	—
Retarded speech development	...	...	...	...	...	...	—	—
Dysphonia	...	...	...	...	...	...	—	—
Other defects—	...	...	...	...	...	...	1	—

<i>Analysis of Cases Discharged</i>								
Number of children discharged	...	...	...	...	...	...	19	5
Speech normal	...	...	...	...	...	...	14	5
Speech improved	...	...	...	...	...	...	3	—
Unsuitable for treatment	...	...	...	...	...	...	—	—
Non-co-operation	...	...	...	...	...	...	1	—
Left school	...	...	...	...	...	...	—	—
Left district	...	...	...	...	...	...	—	—
Other reasons—Unable to attend	...	...	...	...	...	...	1	—

Group 7. Other Treatment Given

					Number of cases known to have been dealt with	
					1960	1959
(a)	Pupils with minor ailments	...	...	...	217	318
(b)	Pupils who received convalescent treatment under School Health Service arrangements	...	...	...	9	12
(c)	Pupils who received B.C.G. vaccination	...	...	...	529	194
(d)	Other than a, b and c above—Ultra Violet Light	...	...	...	28	33
Total					783	557

In addition to the children who received treatment at the Clinic for minor ailments a further five cases were kept under observation, all cases being initially examined by the School Medical Officer.

Of the 28 school children who received ultra violet light treatment at the School Clinic seven were still under treatment at the end of the year. Through the interavailability of clinics 20 pre-school children received ultra violet light treatment, of these 10 were improved and five still under treatment at the end of the year. Altogether 86 sessions were held at the School Clinic and 937 attendances made.

Follow-up of Medical Inspections:

The following is a summary of the domiciliary visits made by Health Visitor/School Nurses during the year.

					1960	1959
Infectious diseases	...	...	...	...	102	109
Handicapped pupils	...	...	...	...	73	21
Neglected and verminous	...	...	...	...	192	159
Routine Medical Inspections—Follow-up	...	...	...	...	119	31
Other visits	...	...	...	...	1,107	644
Total					1,593	964

School Hygiene:

The general state of hygiene remained substantially the same as indicated in previous reports.

Handicapped Pupils:

Details of the number of handicapped pupils are given in the following table:—

TABLE V

	At a Special School	At an Ordinary School	Receiving Home Tuition	Not receiving suitable education
Blind Pupils	1	—	—	—
Partially Sighted Pupils	—	1	—	—
Deaf Pupils	7	—	—	—
Partially Deaf Pupils	3	3	—	—
Educationally Sub-normal Pupils	78	3	—	—
Epileptic Pupils	—	—	—	—
Maladjusted Pupils	3	4	—	—
Physically Handicapped Pupils ...	3	—	3	—
Pupils suffering from Speech Defect	—	—	—	—
Delicate Pupils	—	5	2	—
Total ...	95	16	5	—

Braithwaite Day Special School:

73 children were attending Braithwaite Day Special School by the end of the year as against 63 during the previous year, although eight of these came from the Skipton Division. (There is now a waiting list for admission to this school.)

This school is satisfying a much felt need and the teachers there are undoubtedly doing valuable work in ensuring that these handicapped children are given as much training and education as possible to fit them for their future life in the world.

In addition to the children referred, for which forms 2 H.P. were completed, a further 34 children were examined and found to have I.Qs. between 75 and 85 and were recommended to have special education in the ordinary school. It is hoped that by this means further deterioration in their performance will be avoided. Arrangements have, of course, been made for these children to be kept under constant review.

Nocturnal Enuresis:

During the year several children suffering from nocturnal enuresis were treated with the Eastleigh Electric Warning Device. Seven children in all, four boys and three girls were treated. Three cases were cured quickly; one child became dry for several months and then had a relapse which may have been due to anxiety about the 11+ selection. In the other three cases treatment was still being continued at the end of the year.

Mentally Defective Children:

Two children were notified as being ineducable under the provisions of Section 57(3) of the Education Act, 1944 and three children were reported under the provisions of Section 57(5) of that Act as requiring supervision after leaving school.

Audiometric Survey:

An audiometric survey carried out in connection with the seven year old children attending schools situate within the Borough revealed the following results:—

Number of children tested	...	...	...	...	...	...	603
Number of initial failures	...	...	...	...	...	...	34
Number of children subsequently found by individual tests	...	...	...	...	...	...	14
Number of children found to have defective hearing	...	...	...	...	...	...	11
Number of children who failed to keep appointments for individual test	...	...	...	...	...	...	9

Analysis of children found to have defective hearing:—

Already having treatment under Otologist	...	...	...	...	...	3
Number referred to Otologist	...	...	...	...	...	2
Number of children treated at school clinic for excessive wax	...	...	...	...	...	2
Number of children referred to own General Practitioner for treatment	...	...	...	...	...	4

Nutrition:

Arrangements were continued for the issue of branded foods free of charge to appropriate cases. The distribution of such foods is made on the authorisation of the School Medical Officer who examines each case prior to an issue being approved. The following foods were distributed during the year:—

	1960	1959
Ferromyn (tablets)	210	385
Halibut Liver Oil (capsules)	322	245
Maltoline (bottles)	12	40
Minadex (bottles)	53	91
Vitamin B (capsules)	—	56
Vitamin C (capsules)	—	—

Medical Examination of Entrants to Training Colleges:

Twenty-seven students were medically examined in connection with their applications for entry to Training Colleges which was the same number as was examined in 1959.

Children and Young Persons Act, 1933—Employment of Children:

Fifty-one children were examined by School Medical Officers to determine their fitness for employment under the Authority's bye-laws relating to the employment of children as compared with twenty-four in 1959. The above figures include those children taking part in entertainments. In no case was a child found to be unfit.

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF SCHOOL ENTRANTS:

Tuberculin testing of school entrants was introduced in order that in the case of a positive result it would lead to a search for a source of infection and at the same time secure the placing of the child under medical supervision in order to avoid the risks which follow primary infection.

The following shows details of the work undertaken under the provisions of this scheme:—

No. Invited	Refused	Absent	Previously Examined	Negative	Positive
622	100	96	6	422	3

Of the three cases found to be positive two were referred for X-ray examination and one child was found to have been vaccinated with B.C.G. previously.

B.C.G. VACCINATION OF OLDER SCHOOL CHILDREN:

The Scheme for the vaccination against tuberculosis of older school children continued during the year, details of which are set out below:—

Number of Medical Officers approved to undertake B.C.G. Vaccination 3

Acceptances—

Number of children offered tuberculin testing and vaccination if necessary, whether the offer was made during the year or previously ... 2,559

Number found to have been vaccinated previously ... 678

Number of acceptances ... 582

Percentage of acceptances ... 30.94

Pre-vaccination Tuberculin Test—

Number of children tested ... 565

Result of Heaf Test:

(i) Positive 82; (ii) Negative 483 ... 565

Percentage positive ... 14.51

Vaccination—

Number vaccinated ... 483

Tuberculin test twelve months after vaccination—

Number vaccinated in 1959 ... 194

Number tuberculin tested after 12 months ... 165

Result of test—

(i) Positive 114; (ii) Negative 44; (iii) Not ascertained 7 ... 165

Dental Inspection and Treatment:

The arrangement as regards the dental inspection of pupils is that:—

- Every pupil who is admitted for the first time to a maintained school shall be inspected by a dental officer as soon as possible after the date of admission, and
- Every pupil attending a maintained school or County College shall be inspected by a dental officer on such later occasions as may be practicable and necessary.

Details of the inspections and treatment carried out in connection with this service are given in the following table.

TABLE VI

						1960	1959
Number of pupils inspected—							
At periodic inspections	...	...	...	...	...	1,203	4,280
As specials	...	...	...	...	...	1,728	2,318
					Total	2,931	6,598
Number found to require treatment	...	...	...	...	...	2,462	4,606
Number offered treatment	...	...	...	...	...	2,374	4,329
Number actually treated	...	...	...	...	...	2,156	3,125
Number of attendances	...	...	...	...	...	5,798	7,451
Half-days devoted to: Periodic (School) Inspection						8	33
					Treatment	619	950
					Total	627	983
Fillings: Permanent teeth	...	...	...	...	...	3,836	4,908
Temporary teeth	...	...	...	...	...	64	253
					Total	3,900	5,161
Number of teeth filled: Permanent teeth	...	...	...	...	...	3,608	4,631
Temporary teeth	...	...	...	...	...	63	244
					Total	3,671	4,875
Extractions: Permanent teeth	...	...	...	...	...	1,066	1,662
Temporary teeth	...	...	...	...	...	1,867	2,698
					Total	2,933	4,360
Administration of general anæsthetics for extraction						533	782
Orthodontics—							
Cases commenced during the year	...	...	...	...	...	46	88
Cases carried forward from previous year	...	...	...	...	...	52	48
Cases completed during the year	...	...	...	...	...	53	66
Cases discontinued during the year	...	...	...	...	...	20	18
Pupils treated with appliances	...	...	...	...	...	86	81
Removable appliances fitted	...	...	...	...	...	77	129
Fixed appliances fitted	...	...	...	...	...	29	25
Total attendances	...	...	...	...	...	858	1,109
Number of pupils supplied with artificial dentures	...	...	...	...	...	30	96
Other operations: Permanent teeth	...	...	...	...	...	1,629	2,301
Temporary teeth	...	...	...	...	...	152	59
					Total	1,781	2,360

V. P. McDONAGH
Borough School Medical Officer

SUMMARY

In comparing the services of the School Health Service at the end of 1960 with the services in existence in 1959, it will be noted that a few changes have occurred.

The position can be summarised as follows:—

1. There is still a very great need for residential accommodation for maladjusted children. The residential school which a voluntary body proposed to open in Brighouse in 1960 will not begin to function until September, 1961.
2. There is still a great need for either hostel or residential special school accommodation for maladjusted girls.
3. The Child Guidance Service in the Leeds area requires considerably more help in the provision of Psychiatrists by the Leeds Regional Hospital Board. No Child Psychiatrist has been appointed to take Dr. S. M. Leese's place and it appears that Psychiatrists who normally deal with adults but who are interested in child psychiatry may have to be approached concerning work in the Child Guidance Clinics. The position in the southern half of the County remains good so far as Psychiatric services are concerned.

During the year one part-time Psychiatric Social Worker was appointed in the Doncaster area but there is still a very great national dearth of Psychiatric Social Workers.

4. Approval to increase the establishment of Speech Therapists from 13 to 18 was granted in October, 1960 and it is hoped to have a full establishment by the Autumn. There does appear to be a slight but general increase of Speech Therapists throughout the Country.
5. The number of Pure Tone Audiometers will be increased to nine by the Spring of 1961. It is too early yet to say whether this number will be sufficient. Definite arrangements are now in hand for the setting up early in the Spring of 1961 of two special Audiology Clinics to which cases of hearing loss of especial difficulty can be referred. This experimental start of one half-day per month may well prove to be insufficient but measures can be taken to increase the sessions should the need arise.
6. Full advantage is taken of all refresher courses available to help Medical Officers to keep up-to-date with the present trends of modern treatment.
7. A brief report has been given of the results, to date, of the non-routine medical examination of the intermediate age group of school children and a more comprehensive report will be available next year.